

# Trial Rights and Psychotropic Drugs: The Case Against Administering Involuntary Medications to a Defendant During Trial

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## I. INTRODUCTION

*The right of an accused in a criminal trial to due process is, in essence, the right to a fair opportunity to defend against the State's accusations.<sup>1</sup>*

*Those who have experienced the full thrust of the power of government when leveled against them know that the only protection the citizen has is in the requirement for a fair trial.<sup>2</sup>*

*[I]nvolutionary medication with antipsychotic drugs poses a serious threat to a defendant's right to a fair trial.<sup>3</sup>*

On July 24, 1998, Russell Weston shot and killed two police officers, and wounded a third, near a security checkpoint in the United States Capitol building.<sup>4</sup> Reportedly, Weston's goal was to gain access to the "override console" of the "ruby satellite system," a time machine located in the "great safe of the U.S. Senate," so that he could prevent "cannibals" from taking over and spreading "black heva," a deadly plague.<sup>5</sup> A federal prison psychiatrist diagnosed Weston as suffering from schizophrenia,<sup>6</sup> and the D.C. District

1. *Chambers v. Mississippi*, 410 U.S. 284, 294 (1973).

2. *Donnelly v. DeChristoforo*, 416 U.S. 637, 651 (1974) (Douglas, J., dissenting).

3. *Riggins v. Nevada*, 504 U.S. 127, 138 (1992) (Kennedy, J., concurring in the judgment).

4. *United States v. Weston*, 255 F.3d 873, 874 (D.C. Cir. 2001).

5. *United States v. Weston*, 206 F.3d 9, 19-20 (D.C. Cir. 2000) (Tatel, J., concurring).

6. *Id.* at 11 (per curiam). "Schizophrenia is the paradigmatic illness of psychiatry. It is a clinical syndrome of variable but profoundly disruptive psychopathology, which involves thought, perception, emotion, movement, and behavior. The expression of these symptoms varies across patients and over time, but the cumulative effect of the illness is always severe and usually long lasting." Robert W. Buchanan, M.D. & William T. Carpenter, Jr., M.D., *Schizophrenia: Introduction and Overview*, in KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1096, 1096 (Benjamin J. Sadock & Virginia A. Sadock eds., 7th ed. 2000).

Court found him incompetent to stand trial.<sup>7</sup> A person is competent to stand trial so long as he has “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” and “a rational as well as factual understanding of the proceedings against him.”<sup>8</sup> This competency requirement is based on the recognition that in an adversary system of justice, it is unfair to convict someone who is unable to defend himself.<sup>9</sup> Although treatment with psychotropic medications<sup>10</sup> can sometimes render an in-

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7. *Weston*, 206 F.3d at 11 (per curiam).

8. *Dusky v. United States*, 362 U.S. 402, 402 (1960) (quoting statement of the solicitor general); see also *Drope v. Missouri*, 420 U.S. 162, 171 (1975) (“[A] person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial.”). The prohibition against bringing an incompetent defendant to trial has been traced to English common law. See *Cooper v. Oklahoma*, 517 U.S. 348, 356 (1996) (“The prohibition against trying the incompetent defendant was well established by the time Hale and Blackstone wrote their famous commentaries.” (citations omitted)). Federal and state statutes now specify standards for determining competency to stand trial. See BRUCE J. WINICK, *THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT* 293 n.164 (1997) (noting that “*Dusky* is followed in substance by all jurisdictions, although statutory terminology varies widely”). Incompetence to stand trial is not synonymous with mental illness; a person can be mentally ill, yet still competent to stand trial. See *Lee v. Alabama*, 406 F.2d 466, 471-72 (5th Cir. 1968) (“One may be suffering from a mental disease . . . and simultaneously have a rational and factual understanding of court proceedings and be able to consult with a lawyer on a reasonably rational basis.” (citations omitted)).

9. See *Drope*, 420 U.S. at 171-72 (noting that “the prohibition [against bringing an incompetent defendant to trial] is fundamental to an adversary system of justice”); see also Caleb Foote, *A Comment on Pre-Trial Commitment of Criminal Defendants*, 108 U. PA. L. REV. 832, 834 (1960) (arguing that “the mentally incompetent defendant, though physically present in the courtroom, is in reality afforded no opportunity to defend himself”), quoted in *Drope*, 420 U.S. at 171.

10. Drugs that are used to treat mental illnesses are called “psychotropic.” See Rennie v. Klein, 653 F.2d 836, 839 n.2 (3d Cir. 1981) (“The term ‘psychotropic’ medication refers generally to drugs used in treating psychiatric problems.”). Different kinds of psychotropic drugs are often referred to in terms of the particular disorder they are used to treat. For example, psychotropic drugs that are used to treat psychotic disorders such as schizophrenia are usually called “antipsychotic.” See GERALD C. DAVISON & JOHN M. NEALE, *ABNORMAL PSYCHOLOGY* 305 (8th ed. 2001) (noting that schizophrenia can be treated with “medications collectively referred to as antipsychotic drugs”). The effectiveness of all psychotropic medications is limited to alleviating the symptoms of disorders such as schizophrenia; presently, no pharmacological treatments are capable of curing mental illnesses. See *id.* (noting that antipsychotic medications are not a cure); see also SUSAN NOLEN-HOEKSEMA, *ABNORMAL PSYCHOLOGY* 359-60 (2d ed. 2001) (“People with schizophrenia typically must take neuroleptic drugs prophylactically—that is, all the time to prevent new episodes of acute symptoms.”).

competent detainee competent,<sup>11</sup> Weston refused to take these medications voluntarily.<sup>12</sup>

For more than three years, the federal courts in the District of Columbia struggled with the question of whether Weston could be compelled to take psychotropic medications involuntarily.<sup>13</sup> The

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11. See *United States v. Weston*, 255 F.3d 873, 875 (D.C. Cir. 2001). ("There is treatment available for Weston's illness and its symptoms in the form of antipsychotic medication. The parties agree that such medication is likely the only treatment that can mitigate his schizophrenia and attendant delusions, and thus restore his competence to stand trial." (citation omitted)).

12. See *id.* ("Weston is not currently receiving any such [antipsychotic] medication because, at a time when he was considered medically competent to make a determination, he refused them."). Competence to refuse medical treatment is a separate legal issue from competence to stand trial. Cf. *State v. Garcia*, 658 A.2d 947, 969 (Conn. 1995) (noting the "unusual circumstance in which a trial court finds that a defendant, although incompetent to stand trial, is competent to make his own health care decisions"). In this Note, the term "competence" refers to competence to stand trial, unless otherwise indicated.

13. See *Weston*, 255 F.3d at 873 (affirming district court's decision); *United States v. Weston*, 206 F.3d 9, 14 (D.C. Cir. 2000) (per curiam) (reversing district court's decision); *United States v. Weston*, 194 F.3d 145, 149 (D.C. Cir. 1999) (dismissing appeal when government withdrew opposition to finding detainee incompetent to stand trial); *United States v. Weston*, 134 F. Supp. 2d 115, 138 (D.D.C. 2001) (finding involuntary medication justified to decrease dangerousness to others and render detainee competent to stand trial); *United States v. Weston*, 69 F. Supp. 2d 99, 118 (D.D.C. 1999) (finding involuntary medication justified to decrease dangerousness to self and others); *United States v. Weston*, 55 F. Supp. 2d 23, 27 (D.D.C. 1999) (remanding warden's decision allowing involuntary medication for further proceedings); *United States v. Weston*, 36 F. Supp. 2d 7, 16 (D.D.C. 1999) (granting prosecution's motion to compel a psychiatric examination of the detainee by a government expert).

"Involuntarily" is used in this Note to mean administered under the authority of the court without the consent of the detainee, rather than administered with force or following a physical struggle. Thus, a detainee may take medications cooperatively yet still involuntarily. See *Garcia*, 658 A.2d at 952 n.8 ("[A]n improper court order with which the defendant complies is no less an invasion of his rights than physically forcing compliance with such an improper order. . . . [W]e see no basis, therefore, for distinguishing between forced medication, whereby the defendant is restrained and injected, and medication pursuant to a court order with which the defendant complies."). But see *Riggins v. Nevada*, 504 U.S. 127, 151 (1992) (Thomas, J., dissenting) (suggesting that defendant was not necessarily "forced" to take medication, despite the trial court's refusal to allow him to discontinue the medication); *United States v. Arena*, No. 00CR398(JFK), 2001 U.S. Dist. LEXIS 17522, at \*8 (S.D.N.Y. Oct. 30, 2001) ("The Court finds the distinction between involuntary and forced medication significant."). A gray area does exist when the government initiates medication, yet the detainee does not object. Only a few courts have held that when the government initiates medication, it thereby assumes the burden of proving that the medication will not unjustifiably compromise the detainee's rights. See, e.g., *Rickman v. Dutton*, 864 F. Supp. 686, 713 (M.D. Tenn. 1994) ("Upon its own initiation, the State of Tennessee decided to administer the drugs . . . to [defendant] throughout his trial. Accordingly, the burden was on the State to demonstrate that the administration of such drugs was medically appropriate, and was essential to promote a compelling State interest." (citing *Riggins v. Nevada*, 504 U.S. 127, 138 (1992))). Most courts require that a detainee affirmatively object to the medication; otherwise, the court will assume the detainee took the medication voluntarily. See, e.g., *People v. Jones*, 931 P.2d 960, 980 (Cal. 1997) (observing that "the holding in *Riggins v. Nevada* does not apply in the present case, because defendant did not refuse the medication and was not forced to take the antipsychotic drug" (citing *Riggins*, 504 U.S. at 127)); *Commonwealth v. O'Donnell*, 740

government argued that the medications were necessary both to prevent Weston from harming himself and others and also to render Weston competent to stand trial.<sup>14</sup> Weston's attorneys argued that compelling Weston to take psychotropic medications would violate Weston's liberty interest in refusing medical treatment and his right to a fair trial.<sup>15</sup>

As Weston's case illustrates, determining whether to allow the administration of involuntary psychotropic medications to an incompetent pretrial detainee requires a court to consider multiple interests of both the detainee and the government. In the absence of clear guidance from the Supreme Court,<sup>16</sup> lower courts have reached various conclusions about when the government's interests justify compelling a detainee to take psychotropic medications.<sup>17</sup> Although preventing a detainee from harming himself or others generally has been considered sufficient to justify administering involuntary medications,<sup>18</sup> some courts have found that rendering a detainee competent to stand trial also justifies involuntary medications.<sup>19</sup> Other courts, however, have determined that the government's interest in rendering a detainee competent does not justify involuntary medications.<sup>20</sup> Additionally, some courts have held that whether involuntary medications will violate a detainee's right to a

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A.2d 198, 210 (Pa. 1999) ("Here, unlike in *Riggins*, Appellant never moved to suspend the administration of her . . . medication.").

14. *Weston*, 134 F. Supp. 2d at 116.

15. *Id.* Commentators have suggested that Weston himself most likely has argued that medication is not necessary because he is not suffering from a psychological disorder. *See, e.g.*, E. Fuller Torrey & Mary T. Zdanowicz, *Let Us Treat Them Now*, WASH. POST, Aug. 1, 2000, at A23 ("Weston would never take medication voluntarily because he did not believe he was sick. He really believed—and presumably still believes—that there is a 'ruby red satellite' in the U.S. Capitol that can be used to reverse time."). This lack of insight is observed in many people with schizophrenia. *See id.*; *see also* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 304 (4th ed., text revision 2000) [hereinafter DSM-IV-TR] ("A majority of individuals with schizophrenia have poor insight regarding the fact that they have a psychotic illness.").

16. *See* discussion *infra* Part II.A.

17. *See* discussion *infra* Part II.C.

18. *See* cases cited *infra* note 89; *see also infra* note 24 (discussing government's interest in administering involuntary medications to decrease dangerousness).

19. *E.g.*, *United States v. Weston*, 255 F.3d 873, 876 (D.C. Cir. 2001) (basing decision to allow involuntary medication solely on the government's interest in rendering the detainee competent to stand trial); *Khiem v. United States*, 612 A.2d 160, 168-69 (D.C. 1992) (as amended on rehearing) (finding that the government's interest in rendering the detainee competent justified administering involuntary medications).

20. *E.g.*, *Woodland v. Angus*, 820 F. Supp. 1497, 1511 (D. Utah 1993) (finding that the government's interest in rendering the detainee competent did not justify administering involuntary medications); *United States v. Santonio*, No. 2100-CR-90C, 2001 WL 760932, at \*6 (D. Utah May 3, 2001) (same).

fair trial must be determined before the medications are administered.<sup>21</sup> Conversely, some courts have held that involuntary medications may be administered to an incompetent pretrial detainee without first determining whether the medications will unjustifiably infringe his fair trial rights.<sup>22</sup>

This Note proposes that the best way to resolve this confusion is for courts to decide that government interests cannot justify administering involuntary psychotropic drugs to a defendant during trial. In general, administering involuntary psychotropic drugs infringes an individual's interest in refusing medical treatment,<sup>23</sup> but can be justified by several government interests, particularly the interest in preventing the individual from harming himself or others.<sup>24</sup> During a trial, however, administering involuntary psychotropic drugs infringes not only the interest in refusing medical treatment, but also the right to a fair trial, which cannot be justified by any government interest.<sup>25</sup>

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21. *E.g.*, *United States v. Weston*, 206 F.3d 9, 14 (D.C. Cir. 2000) (per curiam) (requiring "pre-medication resolution of the Sixth Amendment issue"); *United States v. Brandon*, 158 F.3d 947, 960 (6th Cir. 1998) (requiring consideration of the potential effects on the defendant's fair trial rights before allowing involuntary medications).

22. *E.g.*, *Weston*, 255 F.3d at 876 (deferring issue of trial rights until after medications are administered); *United States v. Arena*, No. 00CR398(JFK), 2001 U.S. Dist. LEXIS 17522, at \*8 (S.D.N.Y. Oct. 30, 2001) (ordering involuntary medications without any discussion of trial rights); *see also* cases cited *infra* note 89 (allowing involuntary medications despite the absence of a determination that the medications would not infringe upon the detainee's trial rights).

23. *See Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.").

24. *See Addington v. Texas*, 441 U.S. 418, 426 (1979) ("The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill."); *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 17 (Ohio 2000) ("One state interest that is sufficiently compelling to override an individual's decision to refuse antipsychotic medication is the state's interest in preventing mentally ill persons from harming themselves or others."); *see also Washington v. Harper*, 494 U.S. 210, 227 (1990) (holding that "the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest").

25. *See* discussion *infra* Parts III, IV; *cf. Riggins v. Nevada*, 504 U.S. 127, 138 (1992) (Kennedy, J., concurring in the judgment) ("[I]nvoluntary medication with antipsychotic drugs poses a serious threat to a defendant's right to a fair trial."); *Weston*, 206 F.3d at 12 (per curiam) ("Involuntary antipsychotic medication has the potential to adversely affect the defendant's ability to obtain a fair trial as guaranteed under the Sixth Amendment." (citing *United States v. Brandon*, 158 F.3d 947, 954 (6th Cir. 1998) and *United States v. Morgan*, 193 F.3d 252, 264-65 (4th Cir. 1999))); *State v. Garcia*, 658 A.2d 947, 973 (Conn. 1995) ("[A]lthough antipsychotic drugs can have beneficent effects upon the mentally ill, their side effects also can compromise a criminal defendant's right to a fair trial."); Brief of Amicus Curiae American Psychiatric Association for

As background, Part II of this Note discusses recent cases relating to the administration of involuntary psychotropic medications to an incompetent pretrial detainee. Two cases examined in detail are *United States v. Weston*, decided by the D.C. Circuit Court of Appeals for the second time last July,<sup>26</sup> and *Riggins v. Nevada*, the Supreme Court case that has come the closest to ruling on the issue of administering involuntary psychotropic drugs to incompetent pretrial detainees.<sup>27</sup> Part III discusses the ways that involuntary psychotropic drugs violate the right to a fair trial, including diminishing the defendant's ability to exercise procedural rights, prejudicing the defendant's demeanor, and altering evidence of the defendant's mental state at the time of the offense. Part IV considers counterarguments proposing that involuntary medications do not necessarily violate the right to a fair trial. This part explains why, despite such potentially curative measures as jury instructions and expert witnesses, the government cannot administer involuntary psychotropic medications to a defendant during trial without undermining the fundamental fairness of the trial. Part V proposes that the government should pursue civil commitment rather than criminal prosecution of pretrial detainees whose competence to stand trial depends upon involuntary psychotropic medications. While criminal convictions usually promote such government interests as retribution for past criminal activity and deterrence of future criminal activity, these interests are not well served by convicting a defendant who has not received a fair trial. Because involuntary psychotropic medications pose a substantial threat to the fundamental fairness of a criminal trial, prohibiting the government from administering these medications to a defendant during trial, even if the defendant therefore cannot be brought to trial, results in the "loss" of interests that could not have been gained in the first place.

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Petitioner at 13, *Riggins v. Nevada*, 504 U.S. 127 (1992) (No. 90-8466) (noting that involuntary medication "may tilt the balance of the adversary system against the accused").

26. 134 F. Supp. 2d 115, 115 (D.D.C. 2001), *aff'd*, 255 F.3d 873 (D.C. Cir. 2001); *see also Weston*, 69 F. Supp. 2d 99, 99 (D.D.C. 1999), *rev'd*, 206 F.3d 9 (D.C. Cir. 2000).

27. 504 U.S. at 127.

II. CURRENT CONFUSION ABOUT WHEN THE GOVERNMENT  
MAY ADMINISTER INVOLUNTARY PSYCHOTROPIC  
MEDICATIONS TO AN INCOMPETENT DETAINEE

A. One "Supreme" Source of Confusion: *Riggins v. Nevada*

In 1987, David Riggins was arrested for murder.<sup>28</sup> While in jail, Riggins complained of "hearing voices" and having difficulty sleeping.<sup>29</sup> A psychiatrist prescribed psychotropic medications to treat these symptoms.<sup>30</sup> Despite conflicting opinions from several psychiatrists regarding Riggins's competency, the trial court found Riggins competent to stand trial.<sup>31</sup> Riggins then asked the trial court to allow him to stop taking the medications, arguing that continuing the medications would compromise his right to a fair trial and interfere with his ability to present an insanity defense.<sup>32</sup> After conducting a hearing, at which several psychiatrists gave conflicting testimony about how discontinuing the medications would affect Riggins's competency to stand trial, the trial court denied Riggins's request.<sup>33</sup> The trial court did not, however, explain that its decision was based on the need to medicate Riggins to maintain his competency; in fact, the trial court did not explain its decision at all.<sup>34</sup>

A jury found Riggins guilty and sentenced him to death.<sup>35</sup> The Nevada Supreme Court affirmed the conviction and sentence, rejecting Riggins's claim that the continued administration of involuntary psychotropic medication had violated his right to a fair

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28. *Id.* at 129.

29. *Id.*

30. *Id.*

31. *Id.* at 129-30. This point alone has generated confusion. A significant portion of the oral argument before the Supreme Court was directed at clarifying whether Riggins needed to be medicated to remain competent to stand trial. See U.S. Supreme Court Official Transcript, *Riggins v. Nevada*, 504 U.S. 127 (1992), available at 1992 U.S. TRANS LEXIS 179, at \*7-43. Lower court cases decided since 1992 have almost universally looked to *Riggins* when considering whether to allow the administration of involuntary medication to an incompetent pretrial detainee. See *infra* Part II.C (discussing recent cases). Riggins himself, however, was not found incompetent to stand trial. *Riggins*, 504 U.S. at 130.

32. *Riggins*, 504 U.S. at 130 ("Relying on both the Fourteenth Amendment and the Nevada Constitution, Riggins argued that continued administration of these drugs infringed his freedom and that the drugs' effect on his demeanor and mental state during trial would deny him due process. Riggins also asserted that, because he would offer an insanity defense at trial, he had a right to show jurors his 'true mental state.'").

33. *Id.*

34. *Id.*

35. *Id.* at 131.



trial.<sup>36</sup> The U.S. Supreme Court granted certiorari “to decide whether forced administration of antipsychotic medication during trial violated rights guaranteed by the Sixth and Fourteenth Amendments.”<sup>37</sup> Finding nothing in the trial court’s record to suggest any consideration of either the defendant’s interests in refusing medication or the government’s interests in continuing medication, the Court reversed and remanded the decision of the Nevada Supreme Court,<sup>38</sup> which vacated Riggins’s conviction and ordered a new trial.<sup>39</sup>

The issue the U.S. Supreme Court actually decided in *Riggins* was somewhat different than the one that it set out to decide. What the Court actually decided was not “whether” administration of involuntary medication during trial violated rights guaranteed by the Sixth and Fourteenth Amendments,<sup>40</sup> but rather that such medication “may well have” violated these rights.<sup>41</sup> Because the trial court had not attempted to justify its decision, the only definitive conclusion to be drawn from the Supreme Court’s reversal of this decision is that administering involuntary medications is certain to violate constitutional rights if not justified by any government interest. On remand, the Nevada trial court avoided the question, left unanswered by the U.S. Supreme Court, of what government interests do justify administering involuntary medications, when Riggins decided to plead guilty.<sup>42</sup> For courts that have been confronted with detainees who without medications are not competent to enter a plea,<sup>43</sup> the Supreme Court’s decision in

36. *Id.* at 131-32; see also *Riggins v. State*, 808 P.2d 535, 539 (Nev. 1991) (affirming conviction and sentence).

37. *Riggins*, 504 U.S. at 132-33.

38. *Id.* at 138.

39. *Riggins v. State*, 860 P.2d 705, 705 (Nev. 1993).

40. See *supra* note 37 and accompanying text.

41. *Riggins*, 504 U.S. at 137 (“The court did not acknowledge the defendant’s liberty interest in freedom from unwanted antipsychotic drugs. This error may well have impaired the constitutionally protected trial rights Riggins invokes.”); see also *id.* at 153 (Thomas, J., dissenting) (citing *Riggins*, 504 U.S. at 137):

We took this case to decide “whether forced medication during trial violates a defendant’s constitutional right to a full and fair trial.” Pet. for Cert. The Court declines to answer this question one way or the other, stating only that a violation of *Harper* “may well have impaired the constitutionally protected trial rights Riggins invokes.”

42. *Nevada Briefs*, LAS VEGAS REV.-J., June 22, 1996, at 5B, available at 1996 WL 2343631 (“Instead of going to trial again, Riggins agreed to plead guilty in April to first-degree murder with a deadly weapon and robbery with a deadly weapon. The deal called for Riggins to receive a life prison term, either with or without the possibility of parole.”).

43. A detainee must be competent to enter a plea. See *Medina v. California*, 505 U.S. 437, 448-49 (1992) (“The entry of a plea . . . presupposes that the defendant is competent to stand trial and to enter a plea.”).

*Riggins* has generated much confusion about when involuntary medications may be administered.<sup>44</sup>

One source of confusion in *Riggins* is the Court's reliance on *Washington v. Harper*, a prison regulation case decided two years earlier.<sup>45</sup> This case, as the *Riggins* Court noted, held that although Harper, a convicted prison inmate, did have a liberty interest in refusing psychotropic medication, the compromise of that interest was justified because Harper had been found to pose a danger to himself or others in prison, and because the medication was in Harper's medical interest.<sup>46</sup> The *Riggins* Court did not address, though, the important difference between Harper and Riggins: unlike Riggins, Harper had already been tried and convicted, and thus, the potential of medication to affect the fairness of his trial was not an issue.<sup>47</sup> Although the Court did observe that "[t]he Fourteenth Amendment affords at least as much protection to persons the State detains for trial" as to convicted prisoners,<sup>48</sup> it did not explicitly consider that pretrial detainees need not only the same level of protection but different protections as well, protections that include the right to due process at trial. The Court's failure to distinguish *Riggins* from *Harper* was compounded by its observation that the State of Nevada "certainly would have satisfied due process" if it had demonstrated that Riggins posed a danger to himself or others, that the protection of Riggins and others could not have been achieved through a means less intrusive than medication, and that

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44. See *infra* Parts II.B, C (discussing confusion among lower courts). Some courts have noted explicitly the absence of guidance provided by the *Riggins* decision. See, e.g., *Woodland v. Angus*, 820 F. Supp. 1497, 1510 (D. Utah 1993) (observing that, regarding the question of what interests of the state might justify involuntary medication, "[t]his is the total of the *Riggins* Court's guidance on this issue"); *Harrison v. State*, 635 So. 2d 894, 905 (Miss. 1994) ("[A]lthough [*Riggins*] absolutely mandates that certain findings be made, it does not enlighten as to exactly what those findings must be."); *Riggins v. Nevada*, 860 P.2d 705, 707 (Nev. 1993) (Springer, J., dissenting) ("I . . . find in *Riggins v. Nevada* very little that will guide state courts as to the proper constitutional procedures to be employed in cases involving the forced drugging of criminal defendants."); cf. *Riggins*, 504 U.S. at 140 (Kennedy, J., concurring in the judgment) ("The Court's opinion will require further proceedings on remand, but there seems to be little discussion about what is to be considered.").

45. *Riggins*, 504 U.S. at 133 ("Our discussion in *Washington v. Harper* provides useful background for evaluating [Riggins's] claim." (citing *Washington v. Harper*, 494 U.S. 210 (1990))); *Harper*, 494 U.S. at 222 ("In *Turner v. Safley*, we considered various factors to determine the reasonableness of a challenged prison regulation. Three are relevant here." (referring to 482 U.S. 78 (1987))).

46. *Riggins*, 504 U.S. at 134-35 (citing *Harper*, 494 U.S. at 227).

47. Cf. *Riggins*, 860 P.2d at 708 n.3 (Springer, J., dissenting) (criticizing the Supreme Court for "treating accused Riggins not as a citizen accused of a crime but as a criminal in 'penal confinement'").

48. *Riggins*, 504 U.S. at 135 (citing *Bell v. Wolfish*, 441 U.S. 520, 545 (1979)).

the medication was in Riggins's medical interest.<sup>49</sup> Absent from this list of factors necessary for satisfying due process, however, is a requirement that the government demonstrate that the medication will not violate trial rights guaranteed by the Sixth and Fourteenth Amendments.

The Court's suggestion that virtually the same standard<sup>50</sup> that was appropriate for determining whether to medicate a convicted inmate (Harper) was also appropriate for determining whether to medicate a pretrial detainee (Riggins) seems to ignore the potential of psychotropic medications to abridge the detainee's rights at trial. Yet, the Court did note the possibility that medication had compromised Riggins's defense: "It is clearly possible that . . . side effects had an impact upon not just Riggins'[s] outward appearance, but also the content of his testimony on direct or cross examination, his ability to follow the proceedings, or the substance of his communication with counsel."<sup>51</sup> This statement, recognizing that psychotropic medications can interfere with the ability to present a defense, is not easily reconciled with the statement that due process "certainly" would have been satisfied by a standard that does not include any consideration of how these medications will affect a defendant's rights at trial.

Also uncertain from the Court's opinion is when, if ever, the government's interest in rendering a detainee competent to stand trial can justify involuntary medications. The Court raised but did not unambiguously resolve this issue, indicating only that "the State *might* have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins'[s] guilt or innocence by using less intrusive means."<sup>52</sup> This statement has left lower courts wondering whether "might" means that, in some cases, the government's interest in rendering the detainee competent does justify involuntary medications, or only that the Supreme Court was declining to decide this issue.<sup>53</sup>

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49. *Id.* (emphasis added) (citing *Harper*, 494 U.S. at 225-26).

50. The *Riggins* Court did add a "least intrusive" component to the *Harper* test, 504 U.S. at 135, although whether medication is the least intrusive means of achieving the government's interest in preventing the detainee from harming himself or others is not relevant to the issue of whether medication compromises the detainee's right to receive a fair trial.

51. *Riggins*, 504 U.S. at 137.

52. *Id.* at 135 (emphasis added).

53. See *State v. Garcia*, 658 A.2d 947, 962 (Conn. 1995):

It is unclear whether the Supreme Court, in using the word "might," intended to reserve the issue of whether the state can justify involuntary treatment to restore a defendant to competency for the sole purpose of bringing him to trial,

A concurring opinion by Justice Kennedy is more clear, both in its acknowledgment of the differences between *Harper* and *Riggins*<sup>54</sup> and in its conclusion that a defendant rendered competent by involuntary medications cannot be brought to trial if the medications will preclude him from receiving a fair trial.<sup>55</sup> Some lower courts, however, have ignored Justice Kennedy's insights,<sup>56</sup> while others have either considered yet declined to follow them<sup>57</sup> or suggested that they are no longer as relevant as when *Riggins* was decided.<sup>58</sup>

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or whether the Court intended the word "might" to indicate that such treatment is justified, but only if certain conditions are met.[:]

see also *United States v. Weston*, 69 F. Supp. 2d 99, 111 (D.D.C. 1999) ("The *Riggins* Court . . . stopped short of articulating either the circumstances under or standard by which the Court could medicate a defendant solely to render him competent to stand trial.").

54. *Riggins*, 504 U.S. at 140 (Kennedy, J., concurring in the judgment) ("This is not a case like *Washington v. Harper*. . ."). Interestingly, Justice Kennedy authored the Court's opinion in *Harper*. 494 U.S. at 213.

55. *Riggins*, 504 U.S. at 145 (Kennedy, J., concurring in the judgment) ("If the defendant cannot be tried without his behavior and demeanor being affected in this substantial way by involuntary treatment, in my view the Constitution requires that society bear this cost in order to preserve the integrity of the trial process.").

56. *E.g.*, *State v. Kotis*, 984 P.2d 78, 90-94 (Haw. 1999) (upholding decision to medicate an incompetent pretrial detainee, without reference to Justice Kennedy's concurrence and without consideration of the likely effect of psychotropic medications on the detainee's trial rights). The court concluded that the detainee's dangerousness was sufficient to justify involuntary medication:

In sum, we read *Riggins* to require the following three findings before a criminal defendant may constitutionally be involuntarily medicated with antipsychotic drugs, where it is alleged that the medication is necessary because the defendant poses a danger to himself or herself or others: (1) that the defendant actually poses a danger of physical harm to himself or herself or others; (2) that treatment with antipsychotic medication is medically appropriate, that is, in the defendant's medical interest; and (3) that, considering less intrusive alternatives, the treatment is essential to forestall the danger posed by the defendant.

*Id.* at 93.

57. *E.g.*, *State v. Baker*, 511 N.W.2d 757, 762 (Neb. 1994) ("Although there may be situations where we might agree with Justice Kennedy . . . the present case is not such a situation." (referring to *Riggins*, 504 U.S. at 145)); *State v. Adams*, 888 P.2d 1207, 1211 (Wash. Ct. App. 1995) ("Adams urges this court to follow Justice Kennedy's concurring opinion in *Riggins*. . . . We reject this invitation . . .").

58. *E.g.*, *United States v. Weston*, 255 F.3d 873, 886 n.7 (D.C. Cir. 2001) ("Antipsychotic drugs have progressed since Justice Kennedy discussed their side effects in *Riggins*."); *United States v. Weston*, 134 F. Supp. 2d 115, 134 (D.D.C. 2001) (suggesting that "[a]dvances in the primary antipsychotic medications and adjunct therapies make such side effects [as discussed by Justice Kennedy] less likely" (citing *Riggins*, 504 U.S. at 141-43 (Kennedy, J., concurring))). The concerns raised in Justice Kennedy's concurrence are not so easily resolved, however. See *infra* notes 128-36 and accompanying text (discussing newer antipsychotic medications).

*B. Highlighting the Confusion: United States v. Weston*

In a case that thus far has generated seven decisions and twelve opinions, the federal courts in the District of Columbia have recently considered the question of when the government may administer involuntary psychotropic medications to an incompetent pretrial detainee.<sup>59</sup> Russell Weston has been charged with premeditated murder, attempted murder, and the use of a firearm in the commission of a violent crime.<sup>60</sup> Because the district court found him incompetent to stand trial,<sup>61</sup> Weston was committed to a federal prison hospital, for the purpose of determining whether he could be rendered competent.<sup>62</sup> Whether Weston could be rendered competent, however, depended upon whether he could be compelled to take psychotropic medications.<sup>63</sup>

In its initial review, the D.C. District Court found that Weston posed a safety risk to himself and others, and authorized the government to compel him to take psychotropic medications.<sup>64</sup> Because the district court found that the government's interest in preventing Weston from harming himself and others justified involuntary medications, the district court, citing *Riggins*, did not decide whether the interest in rendering Weston competent to stand trial would also justify involuntary medications.<sup>65</sup> Additionally, the district court did not consider the merits of Weston's argument that administering psychotropic drugs would violate his right to a fair trial; instead, the district court indicated that this issue was not ripe because Weston was not competent to stand trial.<sup>66</sup> The D.C. Circuit Court of Appeals, in a per curiam opinion accompanied by three separate concurrences, reversed, and remanded.<sup>67</sup>

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59. See cases cited *supra* note 13.

60. *United States v. Weston*, 69 F. Supp. 2d 99, 102 (D.D.C. 1999).

61. *Id.*

62. *Id.* at 103.

63. See *supra* notes 7-15 and accompanying text.

64. *Weston*, 69 F. Supp. 2d at 118 ("The Court has found that the proposed medication is medically appropriate and that, considering less intrusive alternatives, it is essential for the defendant's own safety or the safety of others.").

65. *Id.* at 111 ("[The] *Riggins* [case] indicates that if treatment is justified on dangerousness grounds, as it is in the present case, the Court need not reach the issue whether the defendant may be treated solely to render him competent to stand trial.").

66. *Id.* at 117 ("[T]he Court does not find that the legal issues of whether the proposed treatment will interfere with the defendant's Sixth Amendment rights to counsel and to a fair trial to be ripe at this juncture." (citation omitted)).

67. See *United States v. Weston*, 206 F.3d 9, 14 (D.C. Cir. 2000) (per curiam) (Henderson, Rogers & Tatel, JJ., each concurring separately).

On remand, the district court reconsidered two issues: whether sufficient evidence existed to support the finding that Weston was a danger to himself or others, and whether the government's interest in rendering Weston competent to stand trial justified the possible infringement of Weston's trial rights.<sup>68</sup> The district court again found that Weston posed a danger to others.<sup>69</sup> The district court also found that administering involuntary medications would not necessarily deny Weston a fair trial.<sup>70</sup> While acknowledging that psychotropic medications could interfere with Weston's trial rights,<sup>71</sup> the district court identified a variety of methods, such as jury instructions and expert testimony, that might prevent any prejudice caused by the medications from violating these rights.<sup>72</sup> Additionally, the district court observed, citing *Riggins*, that "an essential government interest can sometimes justify trial prejudice."<sup>73</sup>

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68. *United States v. Weston*, 134 F. Supp. 2d 115, 116 (D.D.C. 2000); *see also Weston*, 206 F.3d at 13-15 (remanding to district court).

69. *Weston*, 134 F. Supp. 2d at 131 ("[T]he Court is persuaded that the government has presented additional factual evidence, as well as expert testimony, to support a conclusion that Weston is a danger to those around him."). In considering whether Weston also was a danger to himself, the court found that although three years of untreated psychosis had caused Weston's condition to "progress[ ] to the point where Weston is preoccupied and dominated by his delusional system 'to the exclusion of almost all aspects to existence beyond vegetative functions,'" (quoting report of psychiatrist), the court was "unaware of authority suggesting that this sort of passive deterioration supports a finding of dangerousness to one's self." *Id.* at 127 n.17. "Passive deterioration" might support a finding that Weston has become "gravely disabled," and therefore, is a danger to himself. *See Washington v. Harper*, 494 U.S. 210, 215 n.3 (1990) (noting that one definition of "gravely disabled" is that "a person, as a result of a mental disorder . . . manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety" (quoting WASH. REV. CODE § 71.05.020(1) (1987))). Although Weston, in seclusion for the past three years, might be receiving the care essential for his physical safety, he is certainly not receiving the care essential for his mental health. *See Weston*, 134 F. Supp. 2d at 130 ("Seclusion is simply the warehousing of Weston in a psychotic state."); *see also Anne Hull, A Living Hell or a Life Saved?*, WASH. POST, Jan. 23, 2001, at A1 ("Because Weston has received no treatment and could be dangerous, he has been kept in seclusion for more than two years, an unheard-of period of isolation in modern times.").

70. *Weston*, 134 F. Supp. 2d at 137 ("There is no reason to conclude, at this time, that involuntary medication would preclude Weston from receiving a fair trial.").

71. *Id.* at 132-33 ("Involuntary antipsychotic medication has the potential to adversely affect Weston's ability to obtain a fair trial. . . . Accordingly, before allowing the government to medicate Weston, the Court must consider the potential impact of medication on his fair trial rights." (citation omitted)).

72. *Id.* at 137; *see also infra* note 191 (discussing these measures). The inadequacy of such measures is discussed *infra* Part IV.

73. *Weston*, 134 F. Supp. 2d at 134 (citing *Riggins v. Nevada*, 504 U.S. 127, 138 (1992)). Not even an essential government interest, however, can justify the conviction of a defendant at a trial that lacks a basic, fundamental level of fairness. *See infra* notes 254-58 and accompanying text.

Again, Weston appealed the district court's ruling allowing the government to compel him to take psychotropic drugs. The second panel of the D.C. Circuit Court of Appeals to consider this case affirmed the district court's decision to allow involuntary medications.<sup>74</sup> The court of appeals based its decision, however, solely on the government's interest in rendering Weston competent to stand trial,<sup>75</sup> and not also (as the district court had) on the interest in preventing Weston from harming others.<sup>76</sup> Further, the court of appeals did not decide whether the government's interests justified the possible compromise of Weston's right to a fair trial. Instead, the court of appeals essentially repeated what the district court had first held more than two years earlier, that the question of whether government interests can justify administering involuntary medications to Weston during trial could be deferred until after Weston has been medicated.<sup>77</sup>

Thus, after three years of motions, hearings, opinions, and appeals,<sup>78</sup> the D.C. Circuit Court of Appeals has finally decided<sup>79</sup> that government interests presently justify administering involuntary psychotropic medications to render Weston competent to stand trial,<sup>80</sup> but may or may not justify continuing the medications once Weston's response to them is observed.<sup>81</sup> Undoubtedly, certain as-

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74. See *United States v. Weston*, 255 F.3d 873, 876 (D.C. Cir. 2001).

75. See *id.* (affirming "the district court's conclusion that the government's interest in administering antipsychotic drugs to make Weston competent for trial overrides his liberty interest").

76. The court suggested that the first appellate decision might preclude a finding that involuntary medication is justified by the government's interest in diminishing Weston's dangerousness:

Absent a showing that Weston's condition now exceeds the institution's ability to contain it through his present state of confinement, the prior decision appears to preclude a finding of dangerousness. . . . We need not determine whether our concurring colleague's different interpretation of the previous panel's decision is correct in view of our affirmance of the district court's competency-for-trial ground of decision.

*Id.* at 879 (citing concurring opinion of Rogers, J.) (additional citation omitted).

77. See *id.* at 886 n.8 ("Whether antipsychotic medication will impair Weston's right to a fair trial is best determined when the actual effects of the medication are known, that is, after he is medicated."); *United States v. Weston*, 69 F. Supp. 2d 99, 107 (D.D.C. 1999) ("In the event that medication successfully renders the defendant competent to stand trial, the Court could then reach the defendant's argument that the Due Process Clause or the Sixth Amendment will require a heightened showing before the defendant may be forcibly medicated during the trial.").

78. See cases cited *supra* note 13.

79. A small possibility exists that this decision is not final, as Weston's attorneys have filed a petition for a writ of certiorari from the United States Supreme Court. See *United States v. Weston*, 255 F.3d 873 (D.C. Cir. 2001), *petition for cert. filed*, Sept. 5, 2001 (No. 01-6161).

80. *Weston*, 255 F.3d at 876.

81. See *id.* at 883 (noting "agree[ment] with the district court that 'there is no reason to conclude, at this time, that involuntary medication would preclude Weston from receiving a fair

pects of this case are somewhat unusual, such as the intense attention of the national media.<sup>82</sup> Nonetheless, *United States v. Weston* reflects the general state of confusion that presently exists about when the government may compel an incompetent pretrial detainee to take psychotropic medications.<sup>83</sup>

### *C. The Scope of the Confusion: A Survey of Recent Cases*

Recent cases in which a court has been asked to decide whether the government may compel an incompetent pretrial detainee to take psychotropic medications reveal two major points of disagreement. First, courts disagree about whether a finding that medications are necessary to prevent a detainee from harming himself or others can justify involuntary medications without considering the impact of the medications on the detainee's trial rights.<sup>84</sup> Additionally, courts disagree about whether the government's interest in rendering a detainee competent to stand trial can justify administering involuntary medications when such medications are not also necessary to decrease the detainee's dangerousness.<sup>85</sup>

When the government seeks to administer involuntary psychotropic drugs to an incompetent detainee, usually the first (and sometimes the only) issue that a court considers is whether the detainee poses a danger to himself or others.<sup>86</sup> If the detainee is dan-

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trial' " (quoting *United States v. Weston*, 134 F. Supp. 2d 115, 137 (D.D.C. 2001)) (emphasis added)).

82. See, e.g., *From the Shootings to the Investigation*, WASH. POST, at <http://www.washingtonpost.com/wp-srv/national/longterm/shooting/archives2.htm> (linking stories about the Russell Weston case); *Nightline: Insanity in the Courtroom: When Getting Well May Be a Death Sentence* (ABC television broadcast, Jan. 23, 2001); *20/20: Capitol Gunman* (ABC television broadcast, Sept. 15, 1999).

83. See discussion *infra* Part II.C.

84. Compare cases cited *infra* note 89 (allowing involuntary medications based only on a finding of dangerousness), with *United States v. Weston*, 206 F.3d 9, 14 (D.C. Cir. 2000) (per curiam) (requiring consideration of both dangerousness and trial rights).

85. Compare *Khien v. United States*, 612 A.2d 160, 165-66 (D.C. 1992) (as amended on rehearing) (finding government's interest did justify administering involuntary medications to a nondangerous detainee), and *Weston*, 255 F.3d at 876 (same), with *Woodland v. Angus*, 820 F. Supp. 1497, 1519 (D. Utah 1993) (finding government's interest did not justify administering involuntary medications to a nondangerous detainee), and *United States v. Santonio*, No. 2100-CR-90C, 2001 WL 760932, at \*6 (D. Utah May 3, 2001) (same).

86. "Danger" is used in this Note to mean that the detainee is a danger to himself or others because of a mental illness. Generally, these two criteria will justify involuntary treatment of any person, regardless of whether he has been charged with a crime or found incompetent to stand trial. See *Addington v. Texas*, 441 U.S. 418, 429 (1979) (noting that "the initial inquiry in a civil commitment proceeding is . . . [w]hether the individual is mentally ill and dangerous to either himself or others and is in need of confined therapy . . .").



gerous, the government can attempt to justify involuntary medications on the basis of its interest in preventing the detainee from harming himself or others.<sup>87</sup> In most cases in which a court has reviewed the government's decision to administer involuntary medications to an incompetent detainee, the court has found that the detainee poses a danger to himself or others.<sup>88</sup> Many of these courts have held that a finding of dangerousness is sufficient to justify compelling an incompetent detainee to take psychotropic drugs.<sup>89</sup> The consequence for the detainee is that he can be compelled to take psychotropic medications on the basis of his dangerousness; then, if the medications render him competent, he can be brought to trial without any consideration of whether government interests justify compromising not only his interest in refusing unwanted treatment, but also his right to a fair trial.<sup>90</sup>

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87. See *supra* note 24 (discussing the government's *parens patriae* and police powers).

88. See, e.g., *United States v. Morgan*, 193 F.3d 252, 262 (4th Cir. 1999) (finding that the detainee is a danger to self or others); *United States v. Weston*, 134 F. Supp. 2d 115, 131 (D.D.C. 2001) (same); *United States v. Keeven*, 115 F. Supp. 2d 1132, 1140 (E.D. Mo. 2000) (same); *People v. Tally*, 7 P.3d 172, 176-77 (Colo. Ct. App. 1999), *cert. granted*, 2000 Colo. J. C.A.R. 4959 (Colo. 2000) (en banc), *cert. denied*, 2001 Colo. LEXIS 778 (Colo. Sept. 17, 2001) (en banc) (same); *State v. Kotis*, 984 P.2d 78, 92-93 (Haw. 1999) (same); *State v. Baker*, 511 N.W.2d 757, 762 (Neb. 1994) (same).

89. See, e.g., *Morgan*, 193 F.3d at 262 (concluding that "Morgan's due process rights were adequately protected below, in light of the administrative finding that treatment with antipsychotic medication is necessary because Morgan is dangerous to himself and others."); *Keeven*, 115 F. Supp. 2d at 1140 (recommending that "involuntary medication be re-instituted if it is still the professional judgment of the medical staff that it is necessary to control [defendant's] dangerousness"); *Tally*, 7 P.3d at 176-77 (noting that "administration of the drug was specifically found to be required to prevent defendant from seriously harming himself or others and to prevent a further deterioration in his mental condition"); *Kotis*, 984 P.2d at 92-93 ("*Riggins* suggested that, although a criminal defendant, like any other mental health patient, possesses a fundamental right to refuse treatment threatening his bodily integrity, that right may be overridden by the state's interest in preventing him or her from causing physical harm to self or others."); *Baker*, 511 N.W.2d at 762 (affirming involuntary medication of an incompetent pretrial detainee because "the evidence demonstrated that appellant was mentally ill and dangerous and that the treatment was necessary for the protection of himself as well as others"); cf. *Woodland*, 820 F. Supp. at 1514 n.20 ("A finding that plaintiff presents a danger to himself or others would justify the forcible administration of the drugs." (citing *Washington v. Harper*, 494 U.S. 210, 227 (1990))).

90. The question of whether an incompetent pretrial detainee may be compelled to take psychotropic drugs on the basis of dangerousness to self or others when the drugs "might have the incidental effect of rendering him competent to stand trial," *Morgan*, 193 F.3d at 264, is similar in some respects to the question of whether a prisoner sentenced to death can be compelled to take psychotropic drugs on the basis of dangerousness when an incidental effect of the drugs might be that the prisoner becomes competent to be executed. The Supreme Court has held that the government cannot execute an incompetent prisoner. *Ford v. Wainwright*, 477 U.S. 399, 410 (1986). At least one state supreme court has held that the government cannot administer involuntary medications for the sole purpose of rendering a prisoner competent to be executed. *State v. Perry*, 610 So.2d 746, 771 (La. 1992). When the government argues that involuntary psychotropic medications are needed to prevent the prisoner from harming himself or others,

The government also may seek to administer involuntary medications to an incompetent pretrial detainee who is not a danger to himself or others.<sup>91</sup> If a detainee is not dangerous, involuntary medications cannot be justified by the government's interest in protecting the health and safety of the detainee or others. Instead, the government must justify involuntary medications solely on the basis of its interest in rendering the detainee competent to stand trial.<sup>92</sup> Some courts, applying a strict scrutiny standard of review,<sup>93</sup>

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ers, rather than solely to render the prisoner competent to be executed, determining whether to allow the medications is more complicated. The Eighth Circuit recently decided that it simply could not decide whether the government could administer involuntary medications for the purpose of diminishing dangerousness when the medications might also result in competency to be executed, and granted a permanent stay of execution. *Singleton v. Norris*, 267 F.3d 859, 871 (8th Cir. 2001). For further discussion of the various issues related to competency to be executed, see Roberta M. Harding, "Endgame": *Competency and the Execution of Condemned Inmates—A Proposal to Satisfy the Eighth Amendment's Prohibition Against the Infliction of Cruel and Unusual Punishment*, 14 ST. LOUIS U. PUB. L. REV. 105 (1994); Paul J. Larkin, *The Eighth Amendment and the Execution of the Presently Incompetent*, 32 STAN. L. REV. 765 (1980); John L. Farringer IV, Note, *The Competency Conundrum: Problems Courts Have Faced in Applying Different Standards for Competency to be Executed*, 54 VAND. L. REV. 2441 (2001); Rochelle Graff Salguero, Note, *Medical Ethics and Competency to Be Executed*, 96 YALE L.J. 167 (1986).

91. See, e.g., cases cited *infra* notes 94-97.

92. Department of Justice regulations suggest that the government may medicate a detainee for the sole purpose of rendering him competent to stand trial. The Bureau of Prisons regulations on Medical Services provide that a detainee may be medicated following an administrative hearing at which "[t]he psychiatrist conducting the hearing shall determine whether treatment or psychotropic medication is necessary in order to attempt to make the inmate competent for trial or is necessary because the inmate is dangerous to self or others, is gravely disabled, or is unable to function in the open population of a mental health referral center or a regular prison." Administrative Safeguards for Psychiatric Treatment and Medication, 28 C.F.R. § 549.43(a)(5) (1995). Although this regulation seems to allow administration of involuntary psychotropic medication based solely on a finding that medication is "necessary in order to attempt to make the inmate competent for trial," some courts consider this question unsettled. See, e.g., *United States v. Weston*, 69 F. Supp. 2d 99, 119 (D.D.C. 1999) ("[C]ase law does not clearly indicate whether the government can forcibly medicate a defendant *solely* to render him competent to stand trial."). Interestingly, this is exactly what the D.C. Circuit Court of Appeals recently decided that the government could do. See *United States v. Weston*, 255 F.3d 873, 876 (D.C. Cir. 2001) (affirming district court's decision allowing involuntary medication, based solely on the government's interest in rendering the detainee competent to stand trial).

93. Government actions that compromise "nonfundamental" interests are subject to "rational basis" review. This standard requires a government action to be reasonably related to serving a legitimate government interest. See *Williamson v. Lee Optical*, 348 U.S. 483, 491 (1955) ("We cannot say that the regulation has no rational relation to th[e] [State's] objective and therefore is beyond constitutional bounds."). Government actions that compromise "fundamental" interests are reviewed under a "strict scrutiny" standard, which requires that the action be narrowly tailored to serving a compelling government interest. See *Miller v. Johnson*, 515 U.S. 900, 920 (1995) ("To satisfy strict scrutiny, the State must demonstrate that its . . . legislation is narrowly tailored to achieve a compelling interest." (citation omitted)); see also *Poe v. Ullman*, 367 U.S. 497, 548 (1961) (Harlan, J., dissenting) ("This enactment involves what, by common understanding throughout the English-speaking world, must be granted to be a most fundamental aspect of 'liberty,' . . . and it is this which requires that the statute be subjected to 'strict scru-

have decided that the government's interest in rendering a nondangerous detainee competent to stand trial does not justify administering involuntary medications.<sup>94</sup> Other courts, applying an intermediate or "heightened" standard, have reached inconsistent decisions:<sup>95</sup> some have allowed involuntary medications<sup>96</sup> while some have not.<sup>97</sup> In *Riggins*, the Supreme Court expressly declined to articulate a standard of review for administering involuntary medications to a defendant before or during trial; thus, it remains unclear what the Court would consider to be the appropriate standard of review.<sup>98</sup>

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tiny.' " (quoting *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942))). Courts have also applied an "intermediate" standard of review, which requires government actions to be "substantially related" to "important government objectives." *Craig v. Boren*, 429 U.S. 190, 197 (1976) ("To withstand constitutional challenge, previous cases establish that classifications by gender must serve important governmental objectives and must be substantially related to achievement of those objectives.").

94. *E.g.*, *United States v. Santonio*, No. 2100-CR-90C, 2001 WL 760932, at \*4 (D. Utah May 3, 2001) (indicating that "the court will apply the standard of strict scrutiny to the determination of whether Mr. Santonio may be forcibly medicated" and finding involuntary medications not justified); *cf.* *United States v. Brandon*, 158 F.3d 947, 957 (6th Cir. 1998) (holding that "the government's request to forcibly medicate Brandon must be reviewed under the strict-scrutiny standard" and remanding to the district court for further proceedings (citing *Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir. 1984))).

95. These inconsistent decisions reflect, at least to some extent, inconsistent ideas about how to define those government interests that are sufficiently important to justify involuntary medications. For example, one court found that rendering a detainee, who was charged with second-degree murder, competent to stand trial was not a sufficiently important government interest, *Woodland v. Angus*, 820 F. Supp. 1497, 1519 n.28 (D. Utah 1993), while another court found that rendering a detainee, who was charged with conspiracy to import cocaine, competent to stand trial was a sufficiently important government interest, *United States v. Arena*, No. 00CR398(JFK), 2001 U.S. Dist. LEXIS 17522, at \*9 (S.D.N.Y. Oct. 30, 2001) ("Over half a ton of cocaine is important business and, if the drug laws mean anything, the Government should have an opportunity to bring Mr. Arena to trial."). The problem with a rule that varies the government's ability to administer involuntary medications according to the severity of the offense with which the detainee is charged is that not only does the severity of the charged offense correlate with the magnitude of the government's interest in rendering the detainee competent, it also correlates with the magnitude of the detainee's interest in receiving a fair trial.

96. *E.g.*, *Weston*, 255 F.3d at 880 (applying a "form of heightened scrutiny" and finding involuntary medications justified); *Arena*, 2001 U.S. Dist. LEXIS 17522, at \*7 (asserting that "[t]he *Weston* court enunciated the applicable standard: 'to medicate [a defendant], the government must prove that restoring his competence to stand trial is necessary to accomplish an essential state policy,' " and allowing involuntary medications (quoting *Weston*, 255 F.3d at 880)).

97. *E.g.*, *Woodland v. Angus*, 820 F. Supp. at 1519 n.28 (requiring a "compelling or other significant interest" and finding involuntary medications not justified).

98. *Riggins v. Nevada*, 504 U.S. 127, 136 (1992) ("We have no occasion to finally prescribe . . . substantive standards . . ."). The language used by the majority to describe the nature of both the defendant's and the government's interests is so suggestive of strict scrutiny, however, that the dissent insisted that the majority, despite its denial, was indeed adopting such a standard. *Id.* at 156 (Thomas, J., dissenting). The majority replied, "Contrary to the dissent's understanding, we do not 'adopt a standard of strict scrutiny.'" *Id.* at 136; *see also Brandon*, 158 F.3d at 957 ("On the one hand, the Court [in *Riggins*] seems to have alluded to a strict-scrutiny ap-

A more basic problem, however, than courts' uncertainty about the appropriate standard of review, is courts' failure to consider as two distinct government actions the administration of involuntary psychotropic medications to a detainee who has been convicted of a crime, or who has not been charged with a crime, and the administration of involuntary psychotropic medications to a defendant who is on trial. Generally, involuntary medications infringe a detainee's interest in refusing medical treatment, which the government's interests in preventing harm to the detainee and others can justify.<sup>99</sup> During a trial, however, involuntary medications infringe the detainee's right to a fair trial, which government interests cannot justify.<sup>100</sup>

### III. WHY GOVERNMENT INTERESTS CANNOT JUSTIFY ADMINISTERING INVOLUNTARY PSYCHOTROPIC MEDICATIONS TO A DEFENDANT DURING TRIAL

#### *A. Background: Effects and Side Effects of Antipsychotic Drugs*

In his concurring opinion in *Riggins v. Nevada*, Justice Kennedy observed that administering involuntary antipsychotic medications<sup>101</sup> can violate a defendant's right to a fair trial in two ways:

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proach. . . . On the other hand, the Court's majority opinion makes it clear that it did not set out any standard . . .").

99. See *supra* note 24 (discussing the government's *parens patriae* and police powers). Although the government's interest in preventing harm may justify administering involuntary medications to an incompetent detainee prior to trial, actually administering the medications might require civil commitment proceedings. Under *Jackson v. Indiana*, the government may hold a detainee because he is incompetent to stand trial only until the court determines whether the detainee can be rendered competent, or while treatment is being administered to render the detainee competent. 406 U.S. 715, 738 (1972). If treatment is being administered not to render a detainee competent but to diminish his dangerousness, *Jackson* may preclude the government from continuing to hold the detainee without a civil commitment order. See *id.*

100. See discussion *infra* Parts III, IV.

101. This part focuses on antipsychotic medications, which are commonly used to treat psychotic disorders such as schizophrenia. See *supra* note 10. This is because pretrial detainees who (1) are incompetent to stand trial, and (2) might be rendered competent by psychotropic drugs, are usually suffering from schizophrenia. See, e.g., *United States v. Keeven*, 115 F. Supp. 2d 1132, 1133 (E.D. Mo. 2000) (noting diagnosis of schizophrenia); *United States v. Weston*, 69 F. Supp. 2d 99, 107 (D.D.C. 1999) (same); *People v. Jones*, 931 P.2d 960, 979 (Cal. 1997) (same); *State v. Baker*, 511 N.W.2d 757, 761 (Neb. 1994) (same). While an in-depth discussion of other kinds of psychotropic drugs is beyond the scope of this Note, to the extent that other drugs produce effects and side effects that are similar to those produced by antipsychotic drugs, this discussion is relevant to cases in which the government seeks to compel a detainee to take antidepressant drugs, for example, or antiseizure drugs. See, e.g., *Benson v. Terhune*, 157 F. Supp. 2d 1093, 1100 (N.D. Cal. 2001) ("The drugs taken by petitioner including Valium, Vistaril, and

by altering his demeanor and by interfering with his ability to assist his attorney in presenting a defense.<sup>102</sup> These violations result from the side effects commonly produced by phenothiazines, the kind of antipsychotic medication administered to Riggins,<sup>103</sup> and still the most widely prescribed class of antipsychotic medication.<sup>104</sup> Antipsychotic medications were discovered, somewhat by accident, in the 1950s, when a physician observed that administering phenothiazines prior to surgery reduced the amount of anesthesia required during surgery, because the drugs produced “calmness, conscious sedation, and disinterest in and detachment from external stimuli.”<sup>105</sup> The intended therapeutic effect when prescribed for schizophrenia is the alleviation of some of the most disturbing symptoms of this disorder, including delusions and hallucinations.<sup>106</sup> Psychologists have used the term “positive symptoms” to

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Elavil alter the chemical processes in the mind and may have potential side effects similar to those induced by Mellaril and other anti-psychotic drugs (e.g. sedation, drowsiness, agitation, aggression, inappropriate behavior, and anxiety).”). For a review of the effects and side effects of different kinds of psychotropic drugs, see generally ROBERT M. JULIEN, M.D., PH.D., A PRIMER OF DRUG ACTION (9th ed. 2001).

102. *Riggins*, 504 U.S. at 142 (Kennedy, J., concurring in the judgment) (“The drugs can prejudice the accused in two principal ways: (1) by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom, and (2) by rendering him unable or unwilling to assist counsel.”). The dissent agreed that administration of psychotropic drugs could deprive a defendant of a fair trial, but argued that the evidence did not support a finding that the drugs administered to Riggins had actually deprived him of a fair trial. *Id.* at 154 n.4 (Thomas, J., dissenting).

103. *See id.* at 141-42 (Kennedy, J., concurring in the judgment). The side effects produced by these drugs are discussed in detail *infra* notes 118-26 and accompanying text. Also, the possibility exists that Riggins was overmedicated: “If you are dealing with someone very sick then you may prescribe up to 800 milligrams which is the dose he had been taking which is very, very high. I mean you can tranquilize an elephant with 800 milligrams.” *Riggins*, 504 U.S. at 143 (quoting testimony of psychiatrist). Determining an appropriate therapeutic dose of an antipsychotic medication is often a difficult task. *See* JULIEN, *supra* note 101, at 341 (indicating that “most dosage decisions are made on a trial-and-error basis” because “the plasma concentrations vary widely among patients given similar amounts of orally-administered neuroleptics”).

104. JULIEN, *supra* note 101, at 339 (“The phenothiazines are the most widely used and least expensive drugs for treating psychosis.”).

105. *Id.* at 336.

106. *Id.* at 336-37. The Greek roots of the term “schizophrenia” mean “split mind,” expressing the fracturing of psychological functions that are normally integrated, including thoughts, feelings, perceptions, and behaviors. *See supra* note 6 (describing the symptoms of schizophrenia). Two of the defining symptoms of schizophrenia are delusions and hallucinations. Delusions are “erroneous beliefs that usually involve a misinterpretation of perceptions or experiences.” DSM-IV-TR, *supra* note 15, at 299. Common delusions include delusions of persecution (a person believes that “he or she is being tormented, followed, tricked, spied on, or ridiculed”) and delusions of reference (a person believes that “certain gestures, comments, passages from books, newspapers, song lyrics, or other environmental cues are specifically directed at him or her”). *Id.* Hallucinations are “sensory experiences in the absence of any stimulation from the environment.” DAVISON & NEALE, *supra* note 10, at 285. Among people with schizophrenia, auditory hallucina-

describe experiences, such as delusions and hallucinations, that “reflect an excess or distortion of normal functions.”<sup>107</sup> Researchers believe that abnormal activity in a particular kind of brain cell (neurons activated by the neurotransmitter dopamine) in a particular area of the brain (the limbic system) is at least partly responsible for producing many of the positive symptoms of schizophrenia.<sup>108</sup> All medications that are used to treat schizophrenia have the effect of reducing dopamine activity.<sup>109</sup>

Although a diagnosis of schizophrenia depends upon the presence of positive symptoms,<sup>110</sup> the disorder also involves another category of symptoms, called “negative symptoms.”<sup>111</sup> Negative symptoms reflect a “diminution or loss of normal functions.”<sup>112</sup> Common negative symptoms include restrictions in emotional responsiveness, verbal behavior, social interaction, and motor activity.<sup>113</sup> For most patients, phenothiazines are moderately effective in alleviating the positive symptoms of schizophrenia,<sup>114</sup> but do not improve<sup>115</sup> and may even intensify the negative symptoms.<sup>116</sup> Additionally, these drugs produce substantial side effects;<sup>117</sup> traditional antipsychotic medications are also called neuroleptics, “because

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tions are the most common, and some types of hallucinations, such as hearing a voice speaking one's thoughts, are particularly diagnostic of schizophrenia. *See id.* at 286.

107. DSM-IV-TR, *supra* note 15, at 299; *see also* Billiot v. State, 655 So. 2d 1, 5 (Miss. 1995) (noting that “catatonic excitement, delusions, [and] hallucinations” are “positive symptoms of schizophrenia”); JULIEN, *supra* note 101, at 331 (“The positive symptoms are those typical of psychosis and include delusions and hallucinations, bizarre behaviors, dissociated or fragmented thoughts, incoherence, and illogicality.”).

108. JULIEN, *supra* note 101, at 341.

109. *Id.* at 356.

110. *See* DSM-IV-TR, *supra* note 15, at 312 (listing diagnostic criteria for schizophrenia).

111. *Id.* at 299.

112. *Id.*

113. *See id.*; *see also* State v. Perry, 13 S.W.3d 724, 731 (Tenn. Crim. App. 1999) (noting that “the defendant presents primarily negative symptoms” including “flat affect, an inability to engage in goal directed behavior, [and] a poverty of speech”).

114. *See* JULIEN, *supra* note 101, at 379-80 (indicating that ten to twenty percent of patients do not respond to traditional antipsychotics (quoting S.R. Marder et al., *Schizophrenia*, 16 PSYCHIATRIC CLINICS N. AM. 567-88 (1993))).

115. *Id.* at 332 (noting that “the classic [antipsychotic] agents affect primarily the positive symptoms”).

116. *Id.* (noting that the traditional antipsychotics “may worsen the negative symptomatology of schizophrenia”); Gary D. Tollefson & Todd M. Sanger, *Negative Symptoms: A Path Analytic Approach to a Double-Blind, Placebo- and Haloperidol-Controlled Clinical Trial with Olanzapine*, 154 AM. J. PSYCHIATRY 466, 472 (1997) (noting that “neuroleptic drugs may actually worsen negative symptoms”).

117. *See* JULIEN, *supra* note 101, at 343 (“The therapeutic use of the phenothiazines invariably leads to many side effects.”).

they produce side effects similar to the symptoms of a neurological disease.”<sup>118</sup>

Perhaps the side effect most objectionable to patients taking these drugs is a syndrome called akathisia, which is characterized by a “subjective feeling of anxiety, accompanied by restlessness, pacing, constant rocking back and forth, and other repetitive, purposeless actions.”<sup>119</sup> Other common motor disturbances include “tremors of the fingers, a shuffling gate, and drooling.”<sup>120</sup> Antipsychotics also, as was observed when they were first given to preoperative patients, produce such cognitive and emotional side effects as diminished consciousness and impaired motivation.<sup>121</sup> Some evidence suggests that these drugs also cause memory deficits.<sup>122</sup> Different antipsychotics have different side effect profiles; for example, some tend to cause high levels of sedation but low levels of involuntary motor movements, while others cause low levels of sedation but high levels of involuntary motor movements.<sup>123</sup> People taking these medications to treat the symptoms of schizophrenia often take additional medications to treat the side effects of the antipsychotics.<sup>124</sup> While helpful in preventing the side effects from becoming so both-

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118. DAVISON & NEALE, *supra* note 10, at 305. Although they can be severe, most side effects are temporary, enduring only so long as the drugs are administered. See JULIEN, *supra* note 101, at 342. One side effect, though, is usually permanent, persisting even after the drugs are discontinued. *Id.* Tardive dyskinesia, which develops in ten to twenty percent of patients taking phenothiazines and other traditional antipsychotics, is characterized by “involuntary hyperkinetic movements, often of the face and tongue but also of the trunk and limbs, which can be severely disabling.” *Id.* Another side effect, less common but potentially fatal, is neuroleptic malignant syndrome, which can involve respiratory or cardiac failure. See DSM-IV-TR, *supra* note 15, at 796.

119. JULIEN, *supra* note 101, at 342; see also Simon M. Halstead, Thomas R.E. Barnes & Jeremy Speller, *Akathisia: Prevalence and Associated Dysphoria in an In-patient Population with Chronic Schizophrenia*, 164 BRIT. J. PSYCHIATRY 177, 177 (1994) (“Akathisia can be particularly distressing and difficult to tolerate.”).

120. DAVISON & NEALE, *supra* note 10, at 305. The American Psychological Association has identified six “Medication-Induced Movement Disorders” associated with the use of neuroleptics: “Neuroleptic-Induced Parkinsonism, Neuroleptic Malignant Syndrome, Neuroleptic-Induced Acute Dystonia, Neuroleptic-Induced Acute Akathisia, Neuroleptic-Induced Tardive Dyskinesia, and Medication-Induced Postural Tremor.” DSM-IV-TR, *supra* note 15, at 791.

121. See *supra* note 105 and accompanying text.

122. See Stacy A. Castner, Graham V. Williams & Patricia S. Goldman-Rakic, *Reversal of Antipsychotic-Induced Working Memory Deficits by Short-Term Dopamine D1 Receptor Stimulation*, SCIENCE, Mar. 2000, at 2021 (indicating that “the present findings provide evidence that chronic haloperidol treatment can induce cognitive deficits”).

123. JULIEN, *supra* note 101, at 340 (comparing side effects of different antipsychotic drugs).

124. See *id.* at 343; see also United States v. Weston, 134 F. Supp. 2d 115, 137 (D.D.C. 2001) (indicating that one way to “manage the side effects of antipsychotic medications” is “through supplementary medications”).

ersome that patients refuse to continue taking the antipsychotics,<sup>125</sup> these ancillary medications cause side effects of their own.<sup>126</sup>

From a treatment perspective, the ideal antipsychotic drug would alter the neurotransmitter activity only of the particular brain cells that are functioning abnormally and are thereby causing symptoms of schizophrenia. Although drugs that alleviate the symptoms of schizophrenia without producing any side effects do not yet and perhaps may never exist, researchers are developing drugs that seem to be better than the phenothiazines and other traditional antipsychotics at targeting the specific neurons responsible for producing the symptoms of schizophrenia. Since the *Riggins* decision in 1992, pharmaceutical companies have introduced several new "atypical" antipsychotic drugs, which produce different neurotransmitter effects than the traditional antipsychotics.<sup>127</sup> While these newer drugs reduce dopamine activity, they do so more selectively than the phenothiazines, and they also reduce the activity of other neurotransmitters, especially serotonin.<sup>128</sup> Perhaps because of this different effect on serotonin, atypical antipsychotics are more effective than traditional antipsychotics in alleviating negative symptoms of schizophrenia.<sup>129</sup> Some patients have even described their response to these newer drugs as a "wakening."<sup>130</sup>

Because they reduce dopamine activity more selectively than do the phenothiazines, atypical antipsychotics are less likely to produce extrapyramidal side effects,<sup>131</sup> at least when taken in mod-

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125. Cf. DSM-IV-TR, *supra* note 15, at 791 (noting that movement disorders induced by antipsychotic medications "can lead to non-compliance with treatment"); Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1, 70 (1989) ("Although these side effects are unintended, they are intrinsic to the drugs' benevolent properties and should not be trivialized, particularly since patients frequently experience them to be distressing enough to outweigh the drugs' positive clinical effects.").

126. See Stephen R. Marder, M.D., *Schizophrenia: Somatic Treatment*, in KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1199, 1205 (Benjamin J. Sadock & Virginia A. Sadock eds., 7th ed. 2000) (noting that medications used to manage the extrapyramidal side effects of antipsychotics "cause their own adverse effects including dry mouth, constipation, blurred vision, and often memory loss").

127. See JULIEN, *supra* note 101, at 335-36; see also *United States v. Weston*, 255 F.3d 873, 877 (D.C. Cir. 2001) ("The atypicals, which the government has not ruled out, are newer and 'have a more favorable side effect profile.'" (quoting *Weston*, 134 F. Supp. 2d at 124)).

128. JULIEN, *supra* note 101, at 347 (describing the pharmacodynamics of clozapine).

129. See Stephen M. Stahl, *Selecting an Atypical Antipsychotic by Combining Clinical Experience with Guidelines from Clinical Trials*, 60 (suppl. 10) J. CLINICAL PSYCHIATRY 31, 31 (1999) (noting as one property of atypical antipsychotics that they have "better efficacy for negative symptoms").

130. JULIEN, *supra* note 101, at 348.

131. *Id.* at 335 (indicating that atypicals have a "reduce[d] . . . incidence of abnormal movement-generating side effects").



erate doses.<sup>132</sup> Atypical antipsychotics are, however, likely to cause other substantial side effects. Because each drug produces a different array of neurotransmitter effects, the side effects of atypical antipsychotics vary greatly.<sup>133</sup> Some atypicals, for example, cause extreme sedation,<sup>134</sup> while others are more likely to cause agitation and anxiety.<sup>135</sup> Additionally, atypical antipsychotics are difficult to administer without a patient's cooperation, because unlike the traditional antipsychotics, atypicals are not available in forms that can be injected.<sup>136</sup>

*B. How Administering Involuntary Psychotropic Drugs During Trial Violates the Defendant's Fair Trial Rights*

1. Interference with the Exercise of Procedural Rights

The purpose of a criminal trial is the fair determination of the guilt or innocence of a person accused of a crime.<sup>137</sup> The importance of fairness is reflected in the provisions of the Constitution intended to ensure that someone charged with a crime is not con-

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132. See *id.* at 352; see also DSM-IV-TR, *supra* note 15, at 791-92 ("While newer antipsychotic medications are less likely to cause Medication-Induced Movement Disorders, these syndromes still occur.").

133. JULIEN, *supra* note 101, at 356; see also Christopher S. Thomas & Shon Lewis, *Which Atypical Antipsychotic?*, 172 BRIT. J. PSYCHIATRY 106, 106 (1998) ("The atypical antipsychotics cause fewer extrapyramidal side-effects than older drugs, but the pattern with which they block other brain receptors varies considerably between drugs, which is reflected in different side-effect profiles.").

134. See JULIEN, *supra* note 101, at 349-50 (describing side effects of clozapine).

135. See *id.* at 352 (describing side effects of risperidone). Although permanent side effects such as tardive dyskinesia are unlikely, several atypical antipsychotics do pose a risk of life-threatening side effects, including neuroleptic malignant syndrome. See DSM-IV-TR, *supra* note 15, at 791-92 (noting that newer antipsychotics can cause the same motor disorders as the traditional antipsychotics). Other potentially fatal side effects include agranulocytosis (a blood disorder) and cardiac irregularities. JULIEN, *supra* note 101, at 347, 350. Furthermore, because atypical antipsychotics have been widely available for only slightly more than ten years, any consequences of long-term administration remain to be discovered. See *id.* at 335 (indicating that the first atypical antipsychotic was made widely available in the early 1990s).

136. See Joseph P. McEvoy, Patricia L. Scheifler & Allen Frances (eds.), *The Expert Consensus Guidelines Series: Treatment of Schizophrenia 1999*, 60 (suppl. 11) J. CLINICAL PSYCHIATRY 8, 12 (1999) (noting that traditional antipsychotics are indicated for patients who require "IM [intramuscular] medication," which is "not yet available for the atypicals").

137. See *Rose v. Clark*, 478 U.S. 570, 577-78 (1986) ("Without these basic [constitutional] protections, a criminal trial cannot reliably serve its function as a vehicle for determination of guilt or innocence, and no criminal punishment may be regarded as fundamentally fair." (citation omitted)).

victed without an adequate opportunity to defend himself.<sup>138</sup> The Fifth and Fourteenth Amendments prohibit the federal and state governments, respectively, from depriving a person "of life, liberty or property, without due process of law."<sup>139</sup> The Fifth Amendment further prohibits the government from compelling a defendant to testify against himself.<sup>140</sup> The Sixth Amendment grants several specific procedural rights, including the right to be tried by an impartial jury, to confront witnesses for the prosecution and also to summon witnesses for the defense, and to receive the assistance of counsel.<sup>141</sup> Supreme Court decisions have added several other particular rights to the operational definition of a fair trial, including the right to be present during the trial,<sup>142</sup> to have counsel appointed

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138. *Cf. Pointer v. Texas*, 380 U.S. 400, 404 (1965) ("The fact that this right [to confront witnesses] appears in the Sixth Amendment of our Bill of Rights reflects the belief of the Framers of those liberties and safeguards that confrontation was a fundamental right essential to a fair trial in a criminal prosecution."); *Johnson v. Zerbst*, 304 U.S. 458, 462 (1938) (describing "the safeguards of the Sixth Amendment" as "deemed necessary to insure fundamental human rights of life and liberty").

139. U.S. CONST. amend. V; *id.* amend. XIV, § 1.

140. U.S. CONST. amend. V. This protection afforded by the Fifth Amendment has been applied to the states through the Fourteenth Amendment. *See Malloy v. Hogan*, 378 U.S. 1, 3 (1964).

141. The Sixth Amendment provides:

In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the state and district wherein the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the assistance of counsel for his defense.

U.S. CONST. amend. VI. Many of the protections afforded by the Sixth Amendment have been applied to the states through the Fourteenth Amendment. *See, e.g., Pointer*, 380 U.S. at 406 (applying right to confront prosecution witnesses); *Gideon v. Wainwright*, 372 U.S. 335, 340 (1963) (applying right to receive assistance of counsel).

142. *See Snyder v. Massachusetts*, 291 U.S. 97, 105-06 (1934) (holding that "in a prosecution for a felony the defendant has the privilege under the Fourteenth Amendment to be present in his own person whenever his presence has a relation, reasonably substantial, to the fullness of his opportunity to defend against the charge"). This presence refers to more than being physically present. *Cf. Drope v. Missouri*, 420 U.S. 162, 171 (1975) ("The mentally incompetent defendant, though physically in the courtroom, is in reality afforded no opportunity to defend himself.").

if necessary,<sup>143</sup> to receive assistance of counsel that is effective,<sup>144</sup> to present witnesses<sup>145</sup> and other forms of evidence,<sup>146</sup> and to testify.<sup>147</sup>

Psychotropic drugs can interfere with a defendant's ability to exercise these rights by causing sedation, producing feelings of restlessness and anxiety, diminishing awareness of and interest in events happening in the surrounding environment, disrupting memory, and inducing all manner of motor disturbances.<sup>148</sup> Administering involuntary psychotropic medications is likely to impair many abilities necessary for presenting a defense, including the ability to pay attention to what witnesses, or the attorneys, or anyone else in the courtroom is saying; to offer comments or suggestions or otherwise engage in a dialogue about the trial; to understand and respond to questions while testifying; and even to decide whether to testify.<sup>149</sup> By administering involuntary antipsychotic medications, the government interferes with the defendant's general right to be present, as well as with his more specific rights to receive effective assistance of counsel, to confront witnesses, to present evidence, and to testify on his own behalf.<sup>150</sup>

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143. See *Powell v. Alabama*, 287 U.S. 45, 72 (1932) (holding that "the right to have counsel appointed, when necessary, is a logical corollary from the constitutional right to be heard by counsel").

144. See *McMann v. Richardson*, 397 U.S. 759, 771 n.14 (1970) (noting that "the right to counsel is the right to the effective assistance of counsel" (citations omitted)); cf. *Strickland v. Washington*, 466 U.S. 668, 686 (1984) (defining the standard for effective assistance of counsel).

145. See *Washington v. Texas*, 388 U.S. 14, 23 (1976) (finding right to present witnesses); *Chambers v. Mississippi*, 410 U.S. 284, 302 (1973) ("Few rights are more fundamental than that of an accused to present witnesses in his own defense."). See generally Richard A. Nagareda, *Reconceiving the Right to Present Witnesses*, 97 MICH. L. REV. 1063 (1999) (discussing the history and scope of the right to present witnesses).

146. See *Jenkins v. McKeithen*, 395 U.S. 411, 429 (1969) ("The right to present evidence is, of course, essential to the fair hearing required by the Due Process Clause.").

147. See *Rock v. Arkansas*, 483 U.S. 44, 52 (1987) (holding that the defendant has the right to testify and "present his own version of events in his own words"); *Washington*, 388 U.S. at 19 (referring to defendant's right to present his own "version of the facts"); *In re Oliver*, 333 U.S. 257, 273 (1948) (finding "an opportunity to be heard in his defense" is one of the defendant's rights that is "basic in our system of jurisprudence").

148. See *supra* notes 114-26 and accompanying text (discussing side effects of traditional antipsychotics), notes 131-35 and accompanying text (discussing side effects of atypical antipsychotics).

149. Although the older antipsychotics pose the greatest risk of impairing the defendant's ability to participate, this risk does exist with newer antipsychotic medications as well. See *supra* notes 131-35 and accompanying text (discussing side effects of atypical antipsychotics).

150. The Ninth Circuit recently recognized the impact of involuntary psychotropic medication on the defendant's ability to exercise constitutionally protected rights, holding that a defendant was entitled to retroactive application of *Riggins*:

We conclude that the rule announced in *Riggins*—that states must justify forced medication of the defendant during a criminal trial—is a rule of criminal procedure that implicates the kind of fundamental fairness contemplated in *Teague*. . . . Adherence to the *Riggins* rule is thus necessary for the meaningful

Some courts have suggested that involuntary psychotropic medications actually enhance rather than diminish a defendant's ability to exercise procedural rights.<sup>151</sup> Of course, a defendant whom involuntary psychotropic drugs have rendered competent to stand trial is at least slightly better able to exercise at least some of these rights, compared to when he was incompetent to stand trial.<sup>152</sup> On the other hand, the argument that administering involuntary psychotropic medications benefits the defense overlooks the unfairness of alleviating some symptoms of the defendant's mental illness, thereby rendering him competent to stand trial, but at the same time exacerbating other symptoms, as well as causing a host of debilitating side effects, thereby diminishing his ability to participate in the trial proceedings.<sup>153</sup>

## 2. Prejudiced Demeanor and Diminished Credibility

In addition to exercising the procedural rights necessary for presenting a defense, one of the defendant's roles at trial is to influence jurors in a more passive way: by simply appearing before them

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protection of a defendant's right to counsel, right to confrontation, right to present evidence, and right to a trial free from prejudice. Each of these constitutional rights lies at the heart of the procedural protections designed to ensure a fair trial and uphold the integrity of the criminal justice system.

*Flowers v. Walters*, 239 F.3d 1096, 1107 (9th Cir. 2001). The problem with the "*Riggins* rule" as formulated by the Ninth Circuit is that it assumes that states can justify administering involuntary medications to a defendant during trial, an assumption that arguably is unwarranted. *See supra* Part III; *infra* Part IV (discussing how involuntary medications during trial unjustifiably infringe a defendant's right to a fair trial); *see also* *Heffernan v. Norris*, 48 F.3d 331, 336 (8th Cir. 1995) (Bright, J., dissenting) (noting "the multiplicity of rights at stake in *Riggins*, each of which assumes a vital role in ensuring fundamentally fair and accurate trials").

Of course, a defendant, for a variety of reasons, may not exercise all of his trial rights (indeed, some trial rights are mutually exclusive; a defendant cannot both testify and remain silent). The government should not, however, be allowed to deprive the defendant of the opportunity to exercise any of these rights. This Note is not suggesting that the failure of a defendant to participate fully in the trial proceedings amounts to a violation of due process; only when the government has caused the defendant to be unable to participate fully is due process violated. *See infra* note 233 and accompanying text (discussing significance of the fact that administering involuntary medications to a defendant is a *government action* that precludes a defendant from fully participating in his own trial).

151. *E.g.*, *United States v. Weston*, 134 F. Supp. 2d 115, 133 (D.D.C. 2001) ("Ironically, a strong likelihood exists that medication will enhance some of Weston's trial rights, particularly his right to consult with counsel and to assist in his defense.").

152. *See supra* note 8 (discussing competency to stand trial); *see also infra* notes 230-31 and accompanying text (stressing that the requirements for competency to stand trial are minimal).

153. *See supra* Part III.B (discussing ways that involuntary psychotropic medications interfere with the ability to present a defense).

in the courtroom.<sup>154</sup> A defendant who is taking antipsychotic drugs during trial can, because of the drug's side effects and because of exacerbated negative symptoms, appear emotionally unresponsive, bored, nervous, or restless.<sup>155</sup> None of these is likely to impress a jury favorably.<sup>156</sup> The potential for prejudice is perhaps greatest when the medicated defendant testifies, because the jury may disbelieve everything that the defendant says if he does not appear credible.<sup>157</sup>

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154. See *Riggins v. Nevada*, 504 U.S. 127, 142 (1992) (Kennedy, J., concurring in the judgment) ("It is a fundamental assumption of the adversary system that the trier of fact observes the accused throughout the trial, while the accused is either on the stand or sitting at the defense table.").

155. See *supra* Part III.A (discussing effects and side effects of antipsychotic drugs); see also Brief of Amicus Curiae American Psychiatric Association for Petitioner at 13, *Riggins v. Nevada*, 504 U.S. 127 (1992) (No. 90-8466) ("By administering medication, the State may be creating a prejudicial negative demeanor in the defendant—making him look nervous or restless, for example, or so calm or sedated as to appear bored, cold, unfeeling and unresponsive. . . . That such effects may be subtle does not make them any less real or potentially influential."), quoted in *Riggins*, 504 U.S. at 143 (Kennedy, J., concurring in the judgment); NOLEN-HOEKSEMA, *supra* note 10, at 567 (noting that antipsychotic medications "often render people groggy and passive—surely an inappropriate state in which to attend one's own trial").

156. See *Riggins*, 504 U.S. at 143-44 (Kennedy, J., concurring in the judgment) ("As any trial attorney will attest, serious prejudice could result if medication inhibits the defendant's capacity to react and respond to the proceedings and to demonstrate remorse or compassion."); *United States v. Charters*, 829 F.2d 479, 494 (4th Cir. 1987) (noting that "the jury may be misled by the demeanor of a defendant who appears not to care about the crime (or the victim) or who appears overly anxious at particular moments"); see also *Capitol Hill Shooter* (National Public Radio broadcast, May 16, 2001) (remarks of David Siegel, professor of law at Northeastern University) ("If a defendant's given a medication that makes [him] seem sleepy, and then [he's] listening to testimony about some terrible aspect of [his] case—people being shot, people dying, people in terrible pain—and [he doesn't] seem to show any emotion, then the jury listening to that or watching that defendant can conclude this person is a cold, heartless killer."); cf. FED. R. EVID. 403 advisory committee's notes (acknowledging that some evidence can "induc[e] decision on a purely emotional basis"); *Illinois v. Allen*, 397 U.S. 337, 344 (1970) (allowing disruptive defendant to be removed from courtroom, and noting that "the sight of shackles and gags might have a significant effect on the jury's feelings about the defendant"); Theodore Eisenberg, Stephen P. Garvey & Martin T. Wells, *But Was He Sorry? The Role of Remorse in Capital Sentencing*, 83 CORNELL L. REV. 1599, 1600, 1617 (1998) (describing empirical research demonstrating that jurors' beliefs about a defendant's remorse can influence sentencing, and noting, "One thing a defendant should *not* do if he hopes to convince jurors of his remorse is look bored.").

157. See *Riggins*, 504 U.S. at 142 (Kennedy, J., concurring in the judgment) ("If the defendant takes the stand, as *Riggins* did, his demeanor can have a great bearing on his credibility and persuasiveness, and on the degree to which he evokes sympathy."); WINICK, *supra* note 8, at 295 ("The side effects of medication may so alter the defendant's demeanor that the trier of fact forms the impression that his testimony lacks credibility."). Many courts routinely instruct jurors to consider demeanor when evaluating the credibility of a witness. See, e.g., 1A KEVIN F. O'MALLEY, JAY E. GRENIG, & HON. WILLIAM C. LEE, *FEDERAL JURY PRACTICE AND INSTRUCTIONS: CRIMINAL* § 10.01, at 48 (5th ed. 2000) (specifying that the judge should instruct the jury that among the factors it may consider in deciding whether to believe a witness is the witness's "manner of testifying"); see also *Hall v. Warden*, 313 F.2d 483, 488 (4th Cir. 1963) ("It has long been a well-recognized and accepted principle that the appraisal of the value and weight of the testimony of a witness is to be based not only upon consideration of his spoken word but also

The seminal case recognizing that the government's manipulation of a defendant's appearance can violate the defendant's right to a fair trial is *Estelle v. Williams*.<sup>158</sup> In *Estelle*, the Supreme Court held that the government impermissibly prejudices a defendant by compelling him to appear before the jury wearing a prison uniform.<sup>159</sup> Compelling a defendant to appear in handcuffs or other visible physical restraints can similarly deprive the defendant of a fair trial.<sup>160</sup> Admittedly, prison uniforms and physical restraints directly contradict the presumption of innocence<sup>161</sup> in a way that psychotropic medications might not. With psychotropic medications, the challenge to the presumption of innocence may be less direct: medications can cause a defendant to appear apathetic and cold-hearted, or nervous and lacking in credibility, thereby diminishing the jury's ability to continue believing that the defendant is innocent.<sup>162</sup> Even though the threat posed by medication might be less direct, compelling a defendant to take psychotropic medications and compelling a defendant to appear in a prison uniform or visible restraints are alike in one respect: in both situations, the government is manipulating the jury's impression of the defendant in a way that certainly will impact, and may well determine, the jury's verdict.<sup>163</sup>

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upon observation of his manner of testifying, his demeanor on the witness stand, his gestures, his inflections, his frankness or evasiveness, his intelligence and the reasonableness of his statements."). Textbooks on witness preparation stress that demeanor is an important tool that jurors use to assess credibility: "Evaluations of credibility are heavily influenced by perceptions of trustworthiness. . . . Nonverbal communication and behavior are the primary sources of positive evaluations [of a witness's trustworthiness]. Mannerisms, tone of voice, facial expressions, touch, smiles; jurors evaluate all of these." V. HALE STARR, WITNESS PREPARATION § 7.1.3 (2000).

158. 425 U.S. 501, 512-13 (1976).

159. *Id.* (holding that "the State cannot, consistently with the Fourteenth Amendment, compel an accused to stand trial before a jury while dressed in identifiable prison clothes").

160. *See* Spain v. Rushen, 883 F.2d 712, 716 (9th Cir. 1989) ("Generally, a criminal defendant has a constitutional right to appear before a jury free of shackles." (citing Wilson v. McCarthy, 770 F.2d 1482, 1484 (9th Cir. 1985))); *see also* 2 WAYNE R. LAFAVE, JEROLD H. ISRAEL & NANCY J. KING, CRIMINAL PROCEDURE § 24.2(e), at 466 (2d ed. 1999) (noting a general "right to appear before the jury free from shackles or other physical restraints").

161. *See Estelle*, 425 U.S. at 504-05 ("Courts have . . . determined that an accused should not be compelled to go to trial in prison or jail clothing because of the possible impairment of the presumption [of innocence] so basic to the adversary system."); *see also* 2 LAFAVE, ISRAEL & KING, *supra* note 160, § 24.2(e), at 465 ("Because this presumption [of innocence] is likely to be impaired if the defendant is required to stand trial in prison or jail clothing, the courts have rather consistently held that such a procedure is improper.").

162. *See supra* Part III.B (discussing ways that psychotropic drugs interfere with the ability to present a defense).

163. *See Riggins v. Nevada*, 504 U.S. 127, 142 (1992) (Kennedy, J., concurring in the judgment) ("At all stages of the proceedings, the defendant's behavior, manner, facial expressions, and emotional responses, or their absence, combine to make an overall impression on the trier of

### 3. Altered Evidence of Mental State

Those who are insane<sup>164</sup> have long been excused from legal responsibility for behaviors that would otherwise constitute criminal offenses.<sup>165</sup> Presently, federal law recognizes insanity as an affirmative defense,<sup>166</sup> as do the criminal codes of most states.<sup>167</sup> Some

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fact, an impression that can have a powerful influence on the outcome of the trial.”); *see also* Brief of Amicus Curiae American Psychiatric Association for Petitioner at 13, *Riggins v. Nevada*, 504 U.S. 127 (1992) (No. 90-8466) (arguing that involuntary medication “may tilt the balance of the adversary system against the accused”); *supra* notes 154-57 and accompanying text (indicating that the jury can be misled by the defendant’s drug-affected demeanor). The Supreme Court of New Jersey recently held that a defendant was entitled to a new trial after “testifying before the jury in a visibly disheveled state,” which had resulted from being “denied [while in jail awaiting trial] the basic necessities such as food, soap, water, a clean mattress and blanket, and a comb.” *State v. Maisonet*, 763 A.2d 1254, 1256 (N.J. 2001). The court concluded, “That defendant’s overall appearance, caused by factors beyond his control, may have unduly impugned his credibility in the eyes of jurors is sufficient to establish a constitutional violation.” *Id.* at 1260. Some courts have cited an additional reason for prohibiting the handcuffing or shackling of a defendant, which applies equally to administering involuntary medications: “[T]he fact that a prisoner appears in shackles may, to some extent, deprive him of the free and calm use of all his faculties. The result would be a denial of the fair trial guaranteed under the Sixth Amendment to the Federal Constitution . . . .” *State v. Roberts*, 206 A.2d 200, 203 (N.J. Super. Ct. App. Div. 1965) (citation and internal quotation marks omitted).

164. “Insane” is not a term of art in psychiatry or psychology. Instead, the term “insane” is defined by statutes that allow insanity as a defense. Thus, “insane” means whatever a given legislature decides that it means. *See* DAVISON & NEALE, *supra* note 10, at 536 (“Insanity is a legal concept, not a psychiatric or psychological concept.”). The traditional definition of insanity comes from the 1843 English case of *M’Naghten*. Under *M’Naghten*, insanity means that “at the time of the committing of the act, the party accused was lab[o]ring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong.” *M’Naghten’s Case*, 8 Eng. Rep. 718, 722 (1843). Since *M’Naghten*, various other tests of insanity have been proposed, including the irresistible impulse test, the Durham test, and the ALI Model Penal Code test. *See* RICHARD J. BONNIE, JOHN C. JEFFERIES, JR. & PETER W. LOW, *A CASE STUDY IN THE INSANITY DEFENSE: THE TRIAL OF JOHN W. HINCKLEY, JR.* 14-20 (2d ed. 2000). Research suggests, however, that juries’ decisions are not much influenced by the particular test they are instructed to apply. *See* STANFORD H. KADISH & STEPHEN J. SCHULHOFER, *CRIMINAL LAW AND ITS PROCESSES: CASES AND MATERIALS* 955-56 (6th ed. 1995) (describing research demonstrating that “[t]here is little evidence that different formulations of the insanity defense produce different results in practice”).

165. *See* Stephen J. Morse, *Excusing the Crazy: The Insanity Defense Reconsidered*, 58 S. CAL. L. REV. 777, 781 n.5 (1985) (“The modern insanity defense dates at least from Hadfield’s case.” (citing *Rex v. Hadfield*, 27 State Trials 1281 (1800))); BONNIE, JEFFRIES & LOW, *supra* note 164, at 7 (“From the earliest times, the courts and legislatures have provided for ‘tests’ of criminal responsibility that, if satisfied, would result in an acquittal of crime.”).

166. 18 U.S.C. § 17 (1994).

167. *See* Christopher Slobogin, *An End to Insanity: Recasting the Role of Mental Disability in Criminal Cases*, 86 VA. L. REV. 1199, 1200 n.2 (2000) (noting that “[f]ive states have abolished the [insanity] defense” (citing IDAHO CODE § 18-207 (Michie 1997); KAN. STAT. ANN. § 22-3220 (1995); MONT. CODE ANN. § 46-14-214 (1999); NEV. REV. STAT. ANN. § 174.035 (Michie 1997); UTAH CODE ANN. § 76-2-305 (1999))); *see also* *Leland v. Oregon*, 343 U.S. 790, 800-01 (1952) (upholding the constitutionality of not recognizing insanity as a defense).

states also recognize other defenses, such as partial responsibility, that reduce culpability based on a defendant's abnormal mental state at the time the offense was committed.<sup>168</sup> Additionally, a defendant's mental state at the time of the offense is almost always relevant in a criminal trial, given the prosecution's usual burden of proving that the defendant had the requisite mens rea to be convicted of the charged offense.<sup>169</sup>

Legal scholars have offered various ethical and moral bases for the insanity defense.<sup>170</sup> Juries, however, along with the rest of

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168. See, e.g., *State v. Smith*, 960 P.2d 877, 884 (Or. Ct. App. 1998) (concluding that "a defense of 'partial responsibility' is available when 'knowing' conduct is charged" (interpreting OR. REV. STAT. § 161.300 (1990))). See generally Stephen J. Morse, *Criminal Law: Undiminished Confusion in Diminished Capacity*, 75 J. CRIM. L. & CRIMINOLOGY 1, 20 (1984) ("Partial responsibility is a form of lesser legal insanity: The defendant is claiming that, as a result of mental abnormality, he is not fully responsible for the crime proven against him.").

169. See *United States v. Brawner*, 471 F.2d 969, 1002 (D.C. Cir. 1972) ("Our rule permits the introduction of expert testimony as to abnormal condition if it is relevant to negative, or establish, the specific mental condition that is an element of the crime."); see also Slobogin, *supra* note 167, at 1200 n.2 (noting that all states that have abolished the insanity defense have "maintain[ed] the mens rea alternative"). This "mens rea alternative" resembles one variant of what has been called the "diminished capacity" defense. See Morse, *supra* note 168, at 1 (indicating that the "mens rea variant" of diminished capacity "allows a criminal defendant to introduce evidence of mental abnormality at trial . . . to negate a mental element of the crime charged, thereby exonerating the defendant of that charge"). The defendant's mental state is of course not relevant when the defendant is charged with a strict liability offense. Additionally, states can impose limitations on the kinds of evidence a defendant can present regarding his mental state at the time of the offense. See, e.g., *Montana v. Egelhoff*, 518 U.S. 37, 56 (1996) (holding that a Montana statute, which prohibited a defendant from introducing evidence of voluntary intoxication to negate the mens rea of a charged offense, did not violate due process).

170. For example, Stephen J. Morse writes:

The basic moral issue regarding the insanity defense is whether it is just to hold responsible and punish a person who was extremely crazy at the time of the offense. Those who believe that the insanity defense should be abolished must claim either that no defendant is extremely crazy at the time of the offense or that it is morally proper to convict and punish such people. Neither claim is easy to justify.

Morse, *supra* note 165, at 780; see also *Drew v. Thaw*, 235 U.S. 432, 437 (1914) ("The *sine qua non* of all crimes and misdemeanors at law is a criminal intent. . . . Insane persons are incapable of entertaining a criminal intent, and therefore incapable of committing a crime." (citing treatises HAWKINS, PLEAS OF THE CROWN; HALE, PLEAS OF THE CROWN; BISHOP, NEW CRIMINAL LAW)); ABRAHAM GOLDSTEIN, THE INSANITY DEFENSE 13-14 (1967) ("[T]he insanity defense describes the man who is sufficiently different from the rest of us that he cannot be used as an effective example and who, in quite personal terms, cannot be expected to approach events mindful of the warnings sent to him by the criminal code."), quoted in RALPH REISNER, CHRISTOPHER SLOBOGIN & ARTI RAI, LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 517 (3d ed. 1999). For an in-depth discussion, see Michael S. Moore, *Legal Conceptions of Mental Illness*, in MENTAL ILLNESS: LAW AND PUBLIC POLICY 25 (Baruch A. Brody & H. Tristram Engelhardt, Jr. eds., 1980).



the general public, tend to dislike the insanity defense.<sup>171</sup> One reason for the dislike of the insanity defense is the perception that it allows many defendants to “get away with” their crimes.<sup>172</sup> Because mental states must be inferred from the words and actions of a defendant rather than observed directly or measured objectively, the possibility exists that a defendant is malingering,<sup>173</sup> or trying to deceive the jury into believing that he was insane at the time of the offense.<sup>174</sup> Attitudes towards the insanity defense are not helped when expert witnesses, such as psychiatrists, are perceived as willing to say whatever it is that they are hired to say.<sup>175</sup> In recent years, especially following the verdict in the John Hinckley case,<sup>176</sup> legislatures have made the criteria for successfully presenting an

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171. See VALERIE P. HANS & NEIL VIDMAR, *JUDGING THE JURY* 198 (1986) (noting “a great deal of negative feeling toward the insanity defense,” including “public negativism” and “juries that are, on the whole, suspicious of the insanity plea”).

172. See *id.* at 186 (describing research findings that “people drastically overestimate the use and success of the insanity plea” and mistakenly believe that “the insanity defense allows dangerous people to go free”); see also NOLEN-HOEKSEMA, *supra* note 10, at 682 (“The lay public often thinks of the insanity defense as a means by which guilty people ‘get off.’”).

173. The DSM defines malingering as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.” DSM-IV-TR, *supra* note 15, at 739.

174. See *United States v. Lyons*, 739 F.2d 994, 995 (5th Cir. 1984) (Rubin, J., dissenting) (“Public opposition to any insanity-grounded offense is often based, either explicitly or implicitly, on the view that the plea is frequently invoked by violent criminals who use it to fraudulently evade just punishment.”); HANS & VIDMAR, *supra* note 171, at 195 (discussing results of a study indicating that some jurors are “distrustful of schizophrenic defendants and concerned that they might be making up their mental problems literally to get away with murder” but are less distrustful of “defendants suffering from organic problems [who] could not have generated them merely as an excuse”). Concerns about fraud are, of course, not unique to the insanity defense, but exist in most trials.

175. See Scott E. Sundby, *The Jury as Critic: An Empirical Look at How Capital Juries Perceive Expert and Lay Testimony*, 83 VA. L. REV. 1109, 1126 (1997) (describing research finding that “[j]urors commonly believed that experts would skew their testimony for ‘whomever is paying for their testimony’”); see also Daniel Slater & Valerie P. Hans, *Public Opinion of Forensic Psychiatry Following the Hinckley Verdict*, 141 AM. J. PSYCHIATRY 675, 676 (1984) (reporting that after the *Hinckley* verdict, more than sixty percent of the public had either “no confidence” or only “slight confidence” in expert psychiatric testimony); George F. Will, *Insanity and Success*, WASH. POST, June 23, 1982, at A27 (“Psychiatry as practiced by some of today’s itinerant experts-for-hire is this century’s alchemy. No, that is unfair to alchemists, who were confused but honest. Some of today’s rent-a-psychiatry is charlatanism laced with cynicism.”), *quoted in* BONNIE, JEFFRIES & LOW, *supra* note 164, at 132.

176. See Peter Perl, *Public that Saw Reagan Shot Expresses Shock at the Verdict*, WASH. POST, June 23, 1982, at A8 (discussing reaction to jury’s finding that John Hinckley was not guilty by reason of insanity of charges related to the shooting of President Reagan and others); see also *United States v. Hinckley*, 525 F. Supp. 1342, 1348, 1350-51 (D.D.C. 1981), *aff’d*, 672 F.2d 115 (D.C. Cir. 1982) (holding that the prosecution’s use of evidence obtained from a court-ordered psychiatric examination did not violate the defendant’s privilege against self-incrimination).

insanity defense more difficult; for example, most jurisdictions now require that the defendant prove insanity by clear and convincing evidence.<sup>177</sup> Thus, a defendant who claims that he is not guilty by reason of insanity faces an uphill battle.<sup>178</sup>

The “battle” is made even more difficult by the administration of psychotropic medications, which alleviate the symptoms—or evidence<sup>179</sup>—of insanity. Medications alter the evidence of insanity in two ways. First, medications affect the way that a defendant, if he chooses to testify, describes his mental state at the time of the offense. Antipsychotic drugs alleviate those symptoms of a mental illness, such as delusions and hallucinations, that would be most

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177. See KADISH & SCHULHOFER, *supra* note 164, at 953 (“Responses to the *Hinckley* verdict . . . included adjustments in the burden of proof, changes in the disposition of insanity acquittees, introduction of a separate verdict of ‘guilty but mentally ill’ and complete abolition of the insanity defense.”); see also Morse, *supra* note 165, at 779 (“The shock generated by the verdict in the *Hinckley* case has revived recurrent criticism and efforts to abolish or reform the insanity defense.” (citations omitted)).

178. See Richard J. Bonnie & Christopher Slobogin, *The Role of Mental Health Professionals in the Criminal Process: The Case for Informed Speculation*, 66 VA. L. REV. 427, 477 (1980) (noting that “the factfinder is likely to view with considerable skepticism the defendant’s claim that he did not function as would a normal person under the circumstances”); Sundby, *supra* note 175, at 1139 (describing research demonstrating that “[i]n sum, experts’ explanations of human behavior that run contrary to notions of free will are hard to sell to the jury”). Not all incompetent detainees, if they become competent to stand trial, will want to argue an insanity defense, given that acquittal by reason of insanity can mean an indeterminate commitment to a psychiatric treatment facility. See *Jones v. United States*, 463 U.S. 354, 369 (1983) (“There simply is no necessary correlation between severity of the offense and length of time necessary for recovery. The length of the acquittee’s hypothetical criminal sentence therefore is irrelevant to the purposes of his commitment.”). Additionally, insanity defenses rarely succeed. See DAVISON & NEALE, *supra* note 10, at 531 (“A staggering amount has been written on the insanity defense, even though it is pleaded in less than 1 percent of all cases that reach trial and is rarely successful.”); KADISH & SCHULHOFER, *supra* note 164, at 955 (“Nationally, insanity acquittals probably represent no more than 0.25 percent of terminated felony prosecutions.” (citation omitted)). On the other hand, defendants who were so seriously mentally ill as to be incompetent to stand trial may well want to present a partial responsibility or a diminished capacity defense, see *supra* notes 168-69, which may be easier for the defendant to establish than insanity and may not subject the defendant to indefinite civil commitment. These variations of the insanity defense, like the insanity defense itself, are especially important in cases, such as that of Russell Weston or Andrea Yates, in which the defendant cannot plausibly deny committing the actus reus of the charged offense. See *An Insane System*, WASH. POST, July 30, 2001, at A14 (“The key facts here are not debatable. There is little doubt that Mr. Weston committed the horrifying crimes with which he is charged. Yet the notion of legal insanity has no meaning if it does not describe him.”); *Texas Mother’s Murder Trial Set for Jan. 7*, WASH. POST, Oct. 4, 2001, at A2 (“Yates’[s] lawyers allege that she was suffering from a psychotic form of postpartum depression on June 20 when she drowned her children.”).

179. Cf. *Riggins v. Nevada*, 504 U.S. 127, 139 (1992) (Kennedy, J., concurring in the judgment) (“When the State commands medication during the pretrial and trial phases of the case for the avowed purpose of changing the defendant’s behavior, the concerns are much the same as if it were alleged that the prosecution had manipulated material evidence.” (citing *Brady v. Maryland*, 373 U.S. 83, 87 (1963))).

likely to convince a jury that the defendant was insane at the time of the offense.<sup>180</sup> At trial, a defendant who is taking psychotropic drugs, and is therefore no longer hallucinating or delusional, may be able to describe these symptoms (if at all) only in a calm, detached, or dreamlike manner.<sup>181</sup> The defendant's inability to convey the phenomenological experience of his psychotic symptoms may cause the jury to conclude that, at the time of the offense, the defendant was not suffering from any kind of mental abnormality, or at least not from a mental abnormality serious enough to cause insanity.<sup>182</sup> Second, medications can alter the defendant's demeanor during the trial: a defendant taking a traditional antipsychotic medication is unlikely to appear insane, and a defendant taking a newer antipsychotic may appear completely well.<sup>183</sup> This appearance of sanity at the time of the trial will make all the more unbelievable to a jury the defendant's claim that a serious mental illness

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180. See *supra* notes 114-16 and accompanying text (indicating that antipsychotics are most effective in alleviating positive symptoms).

181. See *United States v. Weston*, 134 F. Supp. 2d 115, 133 (D.D.C. 2001) (noting that Weston's psychiatrist "testified that antipsychotic medication might cause Weston to filter out events that might be too disturbing for him to cope with or to recount events as one would recount a dream" (citation to transcript omitted)); see also *supra* text accompanying note 105 (indicating that antipsychotic medications can cause sedation and apathy).

182. Judge Tatel's concurring opinion in *Weston* describes this problem in compelling detail:

Rendering Weston nondelusional may impair his ability to mount an effective insanity defense. . . . A jury listening to a non-delusional Weston explain, perhaps quite passively, that at the time of the crime he believed he had to save the world from the Ruby Satellite System will be considerably more skeptical than a jury that sees and hears the person Dr. Johnson saw and heard: Russell Weston, delusional and unmedicated, explaining in the present tense that there is a "Ruby Satellite System" and that he in fact went to the Capitol in search of the override console to save the country from "human corpses rotting, turning black, and spreading the most deadliest disease known to mankind."

*United States v. Weston*, 206 F.3d 9, 21 (D.C. Cir. 2000) (Tatel, J., concurring); cf. Benjamin B. Sendor, *Crime as Communication: An Interpretive Theory of the Insanity Defense and the Mental Elements of Crime*, 74 GEO. L.J. 1371, 1415 (1986) ("Irrationality is a vital aspect of the exculpatory nature of insanity because rationality is an essential attribute of intelligible conduct, of behavior an observer, such as a jury, can interpret.").

183. See *supra* notes 114, 129-30 and accompanying text (noting that traditional antipsychotics alleviate the positive symptoms of schizophrenia, while atypicals can alleviate positive and negative symptoms). This is the mirror image of the problem that occurs with credibility, creating a Catch-22 situation: psychotropic medications will either produce side effects, causing the jury to believe that the defendant is cold-hearted or is lying, or will not produce side effects, causing the jury to believe that the defendant was not suffering from a mental defect at the time of the crime. Either way, the defendant that the jury sees, and perhaps convicts, is a creation of the government's decision to administer involuntary psychotropic drugs. See JOSEPH HELLER, CATCH-22 54 (1955) ("Orr was crazy and could be grounded. All he had to do was ask; and as soon as he did, he would no longer be crazy and would have to fly more missions. . . . If he flew them he was crazy and didn't have to; but if he didn't want to he was sane and had to.").

caused him to be unable to distinguish right from wrong, or to resist doing what he knew was wrong.<sup>184</sup>

Evidence of the defendant's mental state at the time of the offense is especially important when the defendant is asserting a defense of insanity, because the defendant is in effect admitting to the actus reus of the crime and denying only the mens rea element.<sup>185</sup> Thus, the only issue in contention at trial is the mental state of the defendant at the time of the offense, an issue the jury cannot help but decide based on its observations of the defendant during the trial.<sup>186</sup>

The practice of instructing the jury to consider the defendant's manner of testifying when evaluating an insanity defense further suggests that altering the way the defendant describes his mental state at the time of the offense will influence the jury's assessment of the defendant's guilt.<sup>187</sup> Also, the ability of a defendant

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184. See *Commonwealth v. Louraine*, 453 N.E.2d 437, 442 (Mass. 1983) ("If the defendant appears calm and controlled at trial, the jury may well discount any testimony that the defendant lacked, at the time of the crime, substantial capacity either to appreciate the wrongfulness of his conduct or to conform the conduct to the requirements of the law."); DAVISON & NEALE, *supra* note 10, at 539 ("If the defendant appears normal, the jury may be less likely to believe that the crime was an act of a disturbed mental state rather than of free will . . ."); John Conley, William O'Barr & E. Allen Lind, *The Power of Language: Presentational Style in the Courtroom*, 1978 DUKE L.J. 1375, 1399 (concluding that a witness's "testimonial style exerts a strong influence on the jury's perception of the substance of testimony").

185. Many courts treat a plea of not guilty by reason of insanity and a plea of guilty similarly, requiring a judge, before accepting the plea, to determine that the defendant is making the plea knowingly and voluntarily. See, e.g., *Wisconsin v. Shegrud*, 389 N.W.2d 7, 12-15 (Wis. 1986) (finding defendant's plea of not guilty by reason of insanity was made freely, knowingly and voluntarily); see also Justine A. Dunlap, *What's Competence Got to Do with It: The Right Not to Be Acquitted by Reason of Insanity*, 50 OKLA. L. REV. 495, 515- 517 (1997) (describing similar cases).

186. See DAVISON & NEALE, *supra* note 10, at 539 ("[J]uries form their judgments of legal responsibility or insanity at least in part on how the defendant appears *during the trial*."); see also *Lawrence v. State*, 454 S.E.2d 446, 451 (Ga. 1995) ("We find merit in the argument that a State's compliance with the requirements in *Riggins* fails to address adequately an accused's interest in the impact his medicated demeanor may have upon the jury's evaluation of his sanity."); *Louraine*, 453 N.E.2d at 442 ("In a case where an insanity defense is raised, the jury are likely to assess the weight of the various pieces of evidence before them with reference to the defendant's demeanor.").

187. See Brief of Amicus Curiae American Psychiatric Association for Petitioner at 12, *Riggins v. Nevada*, 504 U.S. 127 (1992) (No. 90-8466) (noting that "the trial court instructed the jury to consider *Riggins*'[s] 'manner upon the stand' when assessing the credibility of his insanity defense"). Courts commonly instruct juries to consider a witness's "manner on the stand" when assessing credibility. See *supra* note 157; see also *State v. Johnson*, 751 A.2d 298, 362 (Conn. 2000) ("Courts have held that, when the defendant has placed his mental state or character in issue, the jury properly may be asked to consider the defendant's courtroom demeanor." (citations omitted)). In addition to instructions from the court, the prosecutor may urge the jury to consider the defendant's courtroom demeanor as evidence against a claim of insanity. See *Commonwealth v. Hunter*, 695 N.E.2d 653, 657 (Mass. 1998) ("Where the defendant's sanity is at

who is taking psychotropic medications to inform the jury about the effects of these medications implies a recognition that the jury may draw erroneous conclusions about the defendant's guilt based on the defendant's drug-affected presentation at trial.<sup>188</sup> Other methods by which a defendant might be allowed to provide information to the jury about the effects and side effects of psychotropic drugs administered during trial, methods such as discontinuing the drugs briefly so that the defendant can testify in an unmedicated state, similarly acknowledge that psychotropic medications can affect the defendant's functioning in ways that will influence the jury's verdict.<sup>189</sup>

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issue, the prosecution may alert jurors to inconsistencies between the defendant's conduct at trial and his alleged mental illness." (citing *Commonwealth v. Smiledge*, 643 N.E.2d 41 (Mass. 1994))).

188. See *Commonwealth v. Gurney*, 595 N.E.2d 320, 323 (Mass. 1992) (holding that defendant had the right to inform the jury that he was taking antidepressants during the trial because this fact "should have been considered by the jury when assessing [the defendant's] character and credibility, as well as deciding whether he possessed the specific intent to commit the crimes charged"). At least one state, Florida, has enacted a statute mandating that the judge, at the request of the defendant, inform the jury that the defendant is taking psychotropic medications, when the medications are necessary to maintain the defendant's competency to stand trial. FLA. R. CRIM. P. 3.215(c)(2) ("If the defendant proceeds to trial with the aid of medication for a mental or emotional condition, on the motion of defense counsel, the jury shall, at the beginning of the trial and in the charge to the jury, be given explanatory instructions regarding such medication."); see also *Alston v. State*, 723 So. 2d 148, 158 (Fla. 1998) (holding that instructions are required "only when the defendant's ability to proceed to trial is because of such [psychotropic] medication"). The inability of such instructions to protect trial rights adequately is discussed *infra* Part IV.A.

189. See *State v. Garcia*, 658 A.2d 947, 974-75 (Conn. 1995) ("The accused in a criminal trial has the right to present himself to the jury—in speech, appearance and personality—as he really is at the time of trial, and probably was at the time he allegedly committed the crime. In other words, he has the right to be himself without modification of his personality through the forced administration of antipsychotic drugs."); *State v. Posby*, 574 N.W.2d 398, 403 (Mich. Ct. App. 1997) (reversing conviction and remanding for new trial when the trial court refused to allow the defendant to discontinue psychotropic medication three days before he was scheduled to testify, "so that the jury could observe defendant in the manner he was at the time of the shooting (that is, not on any medication)"); *vacated due to death of defendant*, 583 N.W.2d 458 (Mich. 1998); see also *Commonwealth v. Gaboriault*, No. CR 9673CR290A-B, 2001 Mass. Super. LEXIS 127, at \*75 (Mass. Super. Apr. 4, 2001) (citations omitted):

A defendant is entitled to place before the jury any evidence which is at all probative of his mental condition. Thus, where a defendant argues that he lacked criminal intent due to a mental illness, the State and Federal Constitutions may require that the defendant be afforded an opportunity to have a jury observe him in an unmedicated state.

Problems with discontinuing psychotropic medications to allow the jury to observe the defendant while he is in an unmedicated state are discussed *infra* notes 225-28 and accompanying text.

## IV. CONSIDERING POTENTIAL COUNTERARGUMENTS

*A. Prejudicial Effects Cannot Be Cured by Jury Instructions or Additional Evidence*

A trial must be fair, but it need not be perfect.<sup>190</sup> Generally, trial defects, even those undeniably prejudicial to the defense, can be cured by measures such as instructions to the jury or the admission of additional evidence, including the testimony of expert and lay witnesses.<sup>191</sup> Some defects, though, create prejudice that so undermines the fairness of the trial that curative measures are insufficient.<sup>192</sup> A key question, then, is whether jury instructions, witness testimony, or any other additional measures can cure the prejudicial effects of administering involuntary psychotropic drugs to a defendant during trial. So long as a substantial threat exists that these drugs will violate the defendant's constitutional right to a fair trial (which arguably is always<sup>193</sup>), courts should not allow a

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190. See *United States v. Weston*, 206 F.3d 9, 22 (D.C. Cir. 2000) (Tatel, J., concurring) ("[T]he Constitution entitles a criminal defendant to a fair trial, not a perfect one." (quoting *Delaware v. Van Arsdall*, 475 U.S. 673, 681 (1986))).

191. In *Weston*, for example, the district court proposed a variety of methods for explaining to the jury the effects and side effects of involuntary medications, methods that the court suggested would protect Weston's right to a fair trial:

If Weston is medicated and his competency is restored, the Court is willing to take whatever reasonable measures are necessary to ensure that his rights are protected. This may include informing the jurors that Weston is being administered mind-altering medication, that his behavior in their presence is conditioned on drugs being administered to him at the request of the government, and allowing experts and others to testify regarding Weston's unmedicated condition, the effects of the medication on Weston, and the necessity of medication to render Weston competent to stand trial.

*United States v. Weston*, 134 F. Supp. 2d 115, 137 (D.D.C. 2001). The court's willingness to allow jury instructions, expert testimony, lay testimony, and whatever other measures the court might find reasonable, belies the conclusion that any of these (or any other) methods will truly guard against an unfair conviction. See *infra* Part IV (discussing inadequacy of such measures).

192. See *Bruton v. United States*, 391 U.S. 123, 135-37 (1968). In *Bruton*, the Court found the judge's "concededly clear" instructions to the jury to ignore the inadmissible hearsay statements of one codefendant when determining the guilt of another codefendant inadequate to "substitute for petitioner's constitutional right of cross-examination." *Id.* at 137; see also *Estes v. Texas*, 381 U.S. 532, 542-43 (1965) ("It is true that in most cases involving claims of due process deprivations we require a showing of identifiable prejudice to the accused. Nevertheless, at times a procedure employed by the State involves such a probability that prejudice will result that it is deemed inherently lacking in due process.").

193. See *infra* notes 235-39 and accompanying text (proposing that a court cannot determine that a defendant's rights will not be violated by involuntary medications).

defendant who is being administered involuntary psychotropic drugs to be brought to trial.<sup>194</sup>

Administering involuntary antipsychotic drugs violates the right to a fair trial in three ways: by diminishing the defendant's ability to exercise procedural rights, by prejudicing the defendant's demeanor, and by altering evidence of the defendant's mental state at the time of the offense.<sup>195</sup> Diminishing the defendant's ability to exercise procedural rights is incurable both in theory and in practice.<sup>196</sup> While prejudicing the defendant's demeanor and altering evidence of the defendant's mental state at the time of the offense are perhaps curable in theory, are not curable in practice.<sup>197</sup>

### 1. Interference with the Exercise of Procedural Rights

The prejudice caused by diminishing the defendant's ability to exercise procedural rights is completely unamenable to cure, because neither the instructions of a judge, the testimony of defense witnesses, nor the introduction of any other kind of evidence can demonstrate to the jury how the defendant would have interacted differently with his attorney, responded differently to prosecution witnesses, or testified differently had he not been medicated.<sup>198</sup>

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194. *Cf. Estes*, 381 U.S. at 564 (“[T]he criminal trial under our Constitution has a clearly defined purpose, to provide a fair and reliable determination of guilt, and no procedure or occurrence which seriously threatens to divert it from that purpose can be tolerated.”); *Riggins v. Nevada*, 504 U.S. 127, 141 (1992) (Kennedy, J., concurring in the judgment) (arguing that unless the government can “make a showing that there is no significant risk that the medication will impair or alter in any material way the defendant’s capacity or willingness to react to the testimony at trial or to assist his counsel,” the defendant may not be administered involuntary medications); *Bruton*, 391 U.S. at 137 (“[T]he introduction of [codefendant] Evans[s] confession posed a substantial threat to petitioner’s right to confront the witnesses against him, and this is a hazard we cannot ignore.”); *Hamilton v. Vasquez*, 17 F.3d 1149, 1169 (9th Cir. 1994) (Trott, J., concurring and dissenting) (emphasis added) (noting “the long-standing principle . . . that jurors are presumed to follow admonitory instructions given by the court *unless* the information they are ordered to disregard posed a ‘substantial threat’ to a defendant’s Constitutional rights” (quoting *Bruton*, 391 U.S. at 137)).

195. *See supra* Part III.B.

196. *See infra* Part IV.A.1.

197. *See infra* Part IV.A.2-3.

198. Justice Thomas’s dissent in *Riggins* was based in part on this problem of determining which of the defendant’s behaviors to attribute to the defendant himself and which to attribute to the medication: “[Riggins] has not stated how he would have directed his counsel to examine or cross-examine witnesses differently. He has not identified any testimony or instructions that he did not understand.” *Riggins*, 504 U.S. at 149-50 (Thomas, J., dissenting). The difficulty of pointing to discrete instances of prejudice, however, is part of the reason that the majority decided that *Riggins* was entitled to a new trial. *See Riggins*, 504 U.S. at 137; *see also* *Yohn v. Love*, 887 F. Supp. 773, 786 n.21 (E.D. Pa. 1995) (noting that some “errors may require automatic invalida-

Furthermore, even if such demonstrations were possible, they would not compensate for the defendant's lost opportunity actually to interact with his attorney, respond to witnesses, or testify in his own words.<sup>199</sup>

## 2. Prejudiced Demeanor and Diminished Credibility

The effect of involuntary psychotropic drugs on a defendant's demeanor, because it involves the presentation of a kind of evidence rather than the exercise of procedural rights, is at least in theory more amenable to cure.<sup>200</sup> In reality, though, the prejudice caused by the defendant's drug-altered demeanor cannot be separated from everything else that happens at trial.<sup>201</sup> Arguably, the most curable kind of prejudice results from a discrete event, such as an improper act by the prosecutor or an inadmissible statement by a witness. When prejudice is caused by a particular event, a judge can usually instruct the jury to disregard that event.<sup>202</sup> Similarly, the judge can instruct the jury about how to consider particular, identifiable items of evidence—with reference to one codefendant but not to another, for example.<sup>203</sup> Meaningfully instructing a jury regarding in-

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tion of a conviction . . . because prejudice is so likely to occur but so difficult to prove" (citing *Riggins*, 504 U.S. at 127)).

199. See *Riggins*, 504 U.S. at 137-38 ("We also are persuaded that allowing *Riggins* to present expert testimony about the effect of Mellaril on his demeanor did nothing to cure the possibility that the substance of his own testimony, his interaction with counsel, or his comprehension at trial were compromised by forced administration of Mellaril."); see also *Bruton*, 391 U.S. at 135-37 (holding that jury instructions could not compensate for the inability to cross-examine prosecution witness).

200. Many courts have suggested that the prejudicial effects on the defendant's demeanor can be cured. See, e.g., *United States v. Weston*, 206 F.3d 9, 15 (D.C. Cir. 2000) (Henderson, J., concurring) ("[T]he testimony of both lay and expert witnesses, whether on direct or cross, will suffice to address any differences in Weston's appearance."); *People v. Hardesty*, 362 N.W.2d 787, 797 (Mich. Ct. App. 1984) ("[W]e believe that informing the jury of [defendant's] drugged condition adequately protected his right to testify."); *Riggins v. State*, 808 P.2d 535, 538 (Nev. 1991) ("In this case, there was ample expert testimony regarding the effect that the Mellaril had on *Riggins*. . . . [W]e are persuaded that expert testimony was sufficient to inform the jury of the effect of the Mellaril on *Riggins*'[s] demeanor and testimony."), *rev'd*, 504 U.S. 127 (1992).

201. Cf. *Riggins*, 504 U.S. at 142 (Kennedy, J., concurring in the judgment) ("The side effects of antipsychotic drugs may alter demeanor in a way that will prejudice all facets of the defense.").

202. See *infra* note 211 (arguing that prejudice from discrete factors is more curable than prejudice from continuous factors). In some instances, of course, instructions will be insufficient to cure prejudice caused even by a discrete factor. See *Aguilar v. Alexander*, 125 F.3d 815, 820 (9th Cir. 1997) ("There are some extreme situations in which curative instructions will not neutralize the prejudice when evidence is improperly admitted.").

203. FED. R. EVID. 105 ("When evidence which is admissible as to one party or for one purpose but not admissible as to another party or for another purpose is admitted, the court, upon



voluntary psychotropic drugs would require the judge to tell the jury to disregard, or to consider in some limited way, not an event but an effect; or rather, myriad effects, which the judge would likely have considerable difficulty specifying.<sup>204</sup> Even if a judge were to attempt such complex instructions, the complexity of the instructions would likely limit the ability of jurors to follow them.<sup>205</sup> On the other hand, simply informing the jury that the defendant is being administered psychotropic drugs seems unlikely to be very curative: instructions that do not explain how these drugs are affecting the defendant and how the jury should consider this information seem unlikely to avert the jury from basing its assessment of the defendant's character, credibility, or guilt on its observations of the defendant's drug-induced appearance, testimony, and behavior in the courtroom. A problem with explicit instructions, however, is that if the defendant is allowed to introduce evidence about the effects and side effects of psychotropic medications, then instructions by the court concerning these medications might be considered an invasion of the jury's fact-finding province.<sup>206</sup>

Allowing the defendant to present additional evidence about the effects of involuntary psychotropic drugs is no more likely to cure the prejudice caused by these drugs than are instructions from the court. For example, testimony could be provided by an expert witness such as a psychiatrist, who could inform the jury that in his opinion, involuntary psychotropic drugs are causing the defendant to experience certain side effects. Of course, the prosecutor would undoubtedly have his own expert psychiatrist, who would inform the jury that in his opinion, the drugs are not causing the defen-

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request, shall restrict the evidence to its proper scope and instruct the jury accordingly.”). Evidence against one codefendant that is prejudicial to a second codefendant, however, may be grounds for severance of the defendants. FED. R. CRIM. P. 14 (“If it appears that a defendant or the government is prejudiced by a joinder of offenses or of defendants in an indictment or information or by such joinder for trial together, the court may order an election or separate trials of counts, grant a severance of defendants or provide whatever other relief justice requires.”).

204. See *Riggins*, 504 U.S. at 141 (Kennedy, J., concurring in the judgment) (noting that “the inquiry itself is elusive, for it assumes some baseline of normality that experts may have some difficulty in establishing for a particular defendant, if they can establish it at all”); DSM-IV-TR, *supra* note 15, at 301 (describing difficulties that clinicians experience in distinguishing antipsychotic side effects from negative symptoms); see also *supra* note 198 (discussing difficulty of identifying precise effects of psychotropic drugs).

205. Cf. Neil J. Vidmar & Regina A. Schuller, *Juries and Expert Evidence: Social Framework Testimony*, 52 LAW & CONTEMP. PROBS. 133, 164-66 (1989) (summarizing empirical research demonstrating the ineffectiveness of complex jury instructions about eyewitness identification testimony).

206. See *People v. Tally*, 7 P.3d 172, 177 (Colo. Ct. App. 1999) (“The giving of this instruction [regarding involuntary medication] would have been improper because it would have directed the jury to accept, as fact, part of a witness[’s] testimony.”).

dant to experience those side effects. Such a duel of the experts would likely leave the jury confused at best.<sup>207</sup> Furthermore, even if a jury did accept completely a defense expert's assessment that the defendant's demeanor at trial reflected drug-induced side effects rather than character or personality traits,<sup>208</sup> and thus the jury did not count the defendant's apparent apathy or anxiety against him, the jury would still have no positive or affirmative demeanor evidence to count in the defendant's favor.<sup>209</sup> Unlike most incidents at trial that prejudice the defense, allowing the government to present its evidence—the defendant in a drug-altered state—denies the de-

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207. See *supra* note 175 and accompanying text (discussing widespread skepticism regarding psychiatrists testifying as expert witnesses). While this confusion exists to some extent in every case involving expert witnesses, the point here is only that the problems associated with expert testimony, particularly expert testimony from a psychiatrist, mean that the defense does not have an adequate means of curing the government-created prejudice resulting from involuntary medications.

208. Jurors will be predisposed, however, to explain the defendant's appearance and behavior *not* in terms of transient, environmental influences such as medication effects, but in terms of dispositional factors such as the defendant's character or personality. Social psychologists have labeled this bias towards dispositional explanations of the behavior of others the "fundamental attribution error." See Daniel A. Krauss & Bruce D. Sales, *The Effects of Clinical and Scientific Expert Testimony on Juror Decision Making in Capital Sentencing*, 7 PSYCHOL. PUB. POL'Y & L. 267, 279 (2001) (noting that the fundamental attribution error "causes individuals to incorrectly perceive that another's behavior is based on stable dispositions (i.e., traits) rather than situational contexts"). For a detailed discussion of the psychological research, see LEE ROSS & RICHARD E. NISBETT, *THE PERSON AND THE SITUATION: PERSPECTIVES OF SOCIAL PSYCHOLOGY* (1991). Furthermore, overcoming this cognitive bias towards dispositional attributions, and convincing jurors to attribute a defendant's appearance and behavior to an unstable and external factor such as medication, is likely to be difficult because of belief perseverance, another cognitive bias. See Joel D. Lieberman & Jamie Arndt, *Understanding the Limits of Limiting Instructions: Social Psychological Explanations for the Failures of Instructions to Disregard Pretrial Publicity and Other Inadmissible Evidence*, 6 PSYCHOL. PUB. POL'Y & L. 677, 691 (2000) ("Research in the area of belief perseverance has demonstrated that once individuals form a belief, the belief becomes highly resistant to change and influences how they perceive and construct future information."). For a discussion of the psychological research, see Lee Ross & Craig A. Anderson, *Shortcomings in the Attribution Process: On the Origins and Maintenance of Erroneous Social Assessments*, in JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES 144, 144-52 (Daniel Kahneman, Paul Slovic & Amos Tversky eds., 1982).

209. See *Commonwealth v. Louraine*, 453 N.E.2d 437, 442 (Mass. 1983):

The ability to present expert testimony describing the effect of medication on the defendant is not an adequate substitute. At best, such testimony would serve only to mitigate the unfair prejudice which may accrue to the defendant as a consequence of his controlled outward appearance. It cannot compensate for the positive value to the defendant's case of his own demeanor in an unmedicated condition.[;]

see also *State v. Posby*, 574 N.W.2d 398, 403 (Mich. Ct. App. 1997) (finding expert testimony insufficient to compensate for the lost value of allowing the jury to observe defendant unmedicated).

fense the opportunity to present its evidence: the defendant in a nondrug-altered state.<sup>210</sup>

Additionally, jurors cannot reasonably be expected to disregard the days or perhaps weeks that they observed the defendant sitting before them sedated and drooling, or agitated and twitching,<sup>211</sup> or that they listened to the defendant testify about the crime in a rational and disinterested manner.<sup>212</sup> As the Supreme Court suggested in *Bruton v. United States*, the ability to follow some instructions is simply beyond the practical, human limitations of the jury system.<sup>213</sup> The Supreme Court also has held that, on appeal, some defects are not subject to harmless error analysis but require automatic reversal.<sup>214</sup> These “structural errors”<sup>215</sup> cannot be considered harmless both because “it is so difficult to measure their effects on a jury’s decision,”<sup>216</sup> and because they “undermin[e] the

210. Cf. 2 LAFAVE, ISRAEL & KING, *supra* note 160, § 27.6(d), at 471 (“[M]ost errors at trial . . . relate to the introduction or evaluation of particular items of evidence.”).

211. Events that are isolated are less likely to produce incurable prejudice than events that are extended. Compare *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 242 (1940) (holding that the prosecutor’s statements, though apparently improper, were not prejudicial because they were “isolated, casual episodes”), with *Estelle v. Williams*, 425 U.S. 501, 504-05 (1976) (“[T]he constant reminder of the accused’s condition implicit in such distinctive, identifiable attire may affect a juror’s judgment. The defendant’s clothing is so likely to be a continuing influence throughout the trial that . . . an unacceptable risk is presented of impermissible factors coming into play.” (emphasis added)). The effects and side effects of antipsychotic drugs are discussed *supra* Part III.A.

212. See *supra* notes 157, 181-82 and accompanying text (discussing how antipsychotic drugs affect a defendant’s testimony).

213. According to the standard suggested by the Supreme Court in *Bruton*, prejudice is incurable when “the risk that the jury will not, or cannot, follow instructions is so great, and the consequences of failure so vital to the defendant, that the practical and human limitations of the jury system cannot be ignored.” 391 U.S. 123, 135 (1968).

214. The Supreme Court first decided that a violation of the Constitution could be “harmless” in the 1967 case of *Chapman v. California*. See 386 U.S. 18, 24 (1967) (finding that a violation of the defendant’s Fifth Amendment right to remain silent could be harmless, if the government established “beyond a reasonable doubt that the error complained of did not contribute to the verdict obtained”). Violations of most but not all constitutional rights are now subject to harmless-error analysis. See *Sullivan v. Louisiana*, 508 U.S. 275, 279 (1993) (“Although most constitutional errors have been held amenable to harmless-error analysis, some will always invalidate the conviction.” (citations omitted)).

215. See *Arizona v. Fulminante*, 499 U.S. 279, 310 (1991) (describing a structural defect as “affecting the framework within which the trial proceeds, rather than simply an error in the trial process itself”).

216. *United States v. Olano*, 507 U.S. 725, 743 (1993) (Stevens, J., dissenting); see also *Vasquez v. Hillery*, 474 U.S. 254, 263 (1986) (noting that “when a petit jury has been selected upon improper criteria or has been exposed to prejudicial publicity, we have required reversal of the conviction because the effect of the violation cannot be ascertained”); 2 LAFAVE, ISRAEL & KING, *supra* note 160, § 27.6(d), at 471 (“Undoubtedly the characteristic of violations requiring automatic reversal that is most frequently mentioned by the Supreme Court is the ‘inherently indeterminate’ impact of the violation upon the outcome of the trial.”).

structural integrity of the criminal tribunal itself.”<sup>217</sup> Conversely, potentially harmless “trial defects” are those that “occur[ ] during the presentation of the case to the jury.”<sup>218</sup> In *Riggins*, the Supreme Court suggested that compelling a defendant to take psychotropic medications is not subject to harmless error analysis.<sup>219</sup> For the same reasons that the prejudice resulting from administering involuntary psychotropic medications cannot be considered harmless after trial, this prejudice cannot be cured during trial: because altering the defendant’s demeanor will affect the jury in ways that are difficult, if not impossible, to describe precisely, yet are almost certain to influence the jury’s verdict in one way or another, neither the instructions of a judge, the testimony of witnesses, nor the introduction of any other kind of evidence can, with adequate certainty, cure the prejudice resulting from the defendant’s drug-induced demeanor.

### 3. Altered Evidence of Mental State

The impact of involuntary psychotropic medications on a defendant’s ability to present evidence in support of a claim that he was insane at the time of the offense is also an evidentiary problem that might potentially be cured by jury instructions or additional evidence. Perhaps the most obvious means of compensating for the loss of evidence that occurs when an irrational, psychotic detainee is medicated into a rational, competent defendant<sup>220</sup> would be to

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217. *Olano*, 507 U.S. at 743 (quoting *Vasquez*, 474 U.S. at 263-64).

218. *Fulminante*, 499 U.S. at 307-08 (defining “trial error” as “error which occurred during the presentation of the case to the jury, and which may therefore be quantitatively assessed in the context of other evidence presented in order to determine whether its admission was harmless beyond a reasonable doubt”).

219. 504 U.S. 127, 137 (1992) (indicating that “[e]fforts to prove or disprove actual prejudice from the record before us would be futile, and guesses whether the outcome of the trial might have been different if Riggins’[s] motion had been granted would be purely speculative” and “the precise consequences of forcing antipsychotic medication upon Riggins cannot be shown from a trial transcript” (citations omitted)); see also *Castillo v. Stainer*, 997 F.2d 669, 669 (9th Cir. 1993) (“[The case of] *Riggins v. Nevada* . . . held that harmless error analysis should not be applied where the defendant had been involuntarily medicated throughout the trial.”); *Rickman v. Dutton*, 864 F. Supp. 686, 714 (M.D. Tenn. 1994) (holding that “because efforts to prove or disprove actual prejudice from the record before the Court would be ‘futile,’ and the precise consequences of compelling Rickman to take mind-numbing drugs ‘cannot be shown from a trial transcript,’ the Court is foreclosed from conducting harmless error review” (quoting *Riggins*, 504 U.S. at 137)).

220. Of course, that a defendant is rational at trial does not mean that he was sane (or insane) at the time of the crime. However, a jury may well find it harder to believe that a defendant who looks sane at trial was insane at the time of the crime. See *supra* notes 183-86 and accompanying text. Additionally, the manner and substance of the defendant’s testimony at trial

present to the jury some kind of record, such as a videotape, of the defendant made prior to initiating medication.<sup>221</sup> Relying on a videotape to enable the defense to present evidence of insanity, however, raises several concerns. First, if a detainee's best evidence supporting an insanity defense will be a videotape, then the tape becomes very important. Perhaps defense counsel should be present while the tape is being made, to ask those questions that will most fully reveal the detainee's insanity.<sup>222</sup> But, if defense counsel can question the detainee, then the prosecutor will likely want to question him as well. Arguably, if attorneys for the defense and the prosecution are questioning the detainee, the detainee is being tried while incompetent.<sup>223</sup> Further, what if the detainee refuses to cooperate? Will this be held against him, even though he is incompetent to stand trial? Arguably, any policy whereby an incompetent detainee can preserve the ability to present a defense only by producing an evidentiary record of his unmedicated mental state is inconsistent with the principle that a defendant cannot be tried unless he is able to participate in defending himself.<sup>224</sup>

Another means by which a medicated defendant might support a defense of insanity is discontinuing the medications for a brief period during trial. Although a few courts have granted a defendant's request to discontinue involuntary psychotropic medica-

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about his mental state at the time of the crime can influence whether the jury believes he was insane at the time of the crime. *See supra* notes 180-182 and accompanying text.

221. *See United States v. Weston*, 206 F.3d 9, 22 (D.C. Cir. 2000) (Tatel, J., concurring) ("[A]n effective insanity defense might be presented through the testimony of Dr. Johnson, perhaps assisted by videotapes of Weston. On remand, therefore, the district court should review the tapes to determine whether they show Weston in his delusional state, and if so, whether, when combined with psychiatric testimony, they would enable defense counsel to mount an effective insanity defense.").

222. Courts have generally held that a psychiatric evaluation, when requested by the prosecution for the purpose of obtaining evidence with which to counter the defendant's claim of insanity, is not a "critical stage" entitling the defendant to the presence of counsel. *See Buchanan v. Kentucky*, 483 U.S. 402, 424-25 (1987) (holding that the Sixth Amendment does not require the presence of defense counsel during a prosecutor-requested psychiatric evaluation, so long as defense counsel is "informed about the scope and nature of the proceeding" and "the possible uses to which petitioner's statements in the proceeding could be put"). A videotaped session that would be the basis for the defendant's entire defense, however, is arguably a "critical stage." *Cf. United States v. Wade*, 388 U.S. 218, 224 (1967) (defining a "critical stage" as a proceeding "where the results might well settle the accused's fate and reduce the trial itself to a mere formality").

223. On the other hand, the absence of court involvement in the making of the tape might result in questions about the tape's admissibility. *See State v. Santos*, 902 P.2d 510, 517 (Mont. 1995) (holding trial court was justified in refusing to admit videotapes of the defendant in an unmedicated state in part because "[t]he probative value of the videotapes is suspect considering the circumstances under which they were made, including that Santos was not under oath").

224. *See supra* note 8 (discussing competency to stand trial).

tions during at least part of the trial,<sup>225</sup> this means of attempting to overcome the prejudice caused by these medications is risky. No way exists for predicting a defendant's behavior while unmedicated, and the defendant may become incompetent and may remain incompetent even when medications are again administered.<sup>226</sup> Also, discontinuing the medications does not necessarily mean that even a previously psychotic defendant will experience a recurrence of psychotic symptoms, or if psychotic symptoms do recur, that they will be the same psychotic symptoms the defendant experienced at the time of the offense.<sup>227</sup> Finally, this option is only even theoretically possible when involuntary medications are not justified by the defendant's dangerousness, given the government's interest in protecting the safety of the defendant and the people around the defendant, both in and out of the courtroom.<sup>228</sup>

*B. Judicial Assessment of Medication Effects Cannot Protect  
Against an Unfair Trial*

Some courts seem to assume that any prejudice caused by psychotropic medications will be addressed as a competency to stand trial issue.<sup>229</sup> The standard for assessing competency to stand

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225. *E.g.*, State v. Hayes, 389 A.2d 1379, 1382 (N.H. 1978) (ruling that "the trial court may compel the defendant to be under medication at least four weeks prior to trial . . . if at some time during the trial, assuming the defendant so requests the jury views him without medication for as long as he is found to have been without it at the time of the crime").

226. See Richard Jed Wyatt, *Neuroleptics and the Natural Course of Schizophrenia*, 17 SCHIZOPHRENIA BULL. 325, 325 (1991) (noting that "there is evidence that stable schizophrenic patients whose neuroleptics are discontinued and have relapses may have a difficult time returning to their previous level of function").

227. See JULIEN, *supra* note 101, at 345 ("Neuroleptic withdrawal can be followed by psychotic exacerbation or relapse, although not all patients relapse after medication withdrawal.").

228. See *supra* note 24 (discussing government's *parens patriae* and police power interests in preventing harm). While handcuffing or otherwise restraining a defendant in the courtroom might diminish the defendant's dangerousness, compelling a defendant to appear before the jury in physical restraints presents its own problems. See *supra* notes 158-63 and accompanying text.

229. See, *e.g.*, United States v. Morgan, 193 F.3d 252, 264 (4th Cir. 1999) (noting that if rendered competent by involuntary medication, the defendant "would not simply be thrust into the courtroom for trial without additional procedural protections" but that "he would be statutorily entitled to have a district judge conduct a pretrial examination of his competency to stand trial"); see also William P. Ziegelmüller, Note, *Sixth Amendment—Due Process on Drugs: The Implications of Forcibly Medicating Pretrial Detainees with Antipsychotic Drugs*: *Riggins v. Nevada*, 112 S. Ct. 1810 (1992), 83 J. CRIM. L. & CRIMINOLOGY 836, 865 (1993) (arguing that the majority opinion in *Riggins* "ignored the fact that a defendant on antipsychotic drugs must still be competent to stand trial. The test to determine competency specifically determines if the defendant has the cognitive capability to consult with her lawyer and follow the proceedings against her—the very abilities the Court believed could be affected by antipsychotic drugs."). A court is required to

trial is not, however, adequate for preventing violations of the right to a fair trial when the defendant is compelled to take psychotropic drugs during trial. Courts interpret the competency to stand trial standard very narrowly, as requiring only a basic cognitive ability to understand and assist in the proceedings.<sup>230</sup> This narrow interpretation means that drug-induced impairments in a defendant's emotional, motivational, attentional, or behavioral ability to participate are unlikely even to trigger a review of the defendant's competency to stand trial, much less support a finding of incompetence.<sup>231</sup>

Several courts have suggested that in addition to the usual competency to stand trial review, a broader judicial assessment of the medication effects and side effects experienced by the defendant can protect the trial rights of a defendant to whom the government is administering involuntary medications.<sup>232</sup> What sort of standard

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investigate any bona fide doubts about the defendant's competency, at any time during the trial. *See Pate v. Robinson*, 383 U.S. 375, 385-87 (1966).

230. *See Godinez v. Moran*, 509 U.S. 389, 402 (1993) ("Requiring that a criminal defendant be competent has a modest aim: It seeks to ensure that he has the capacity to understand the proceedings and to assist counsel."); *see also* GARY MELTON, JOHN PETRILA, NORMAN POYTHRESS & CHRISTOPHER SLOBOGIN, *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS* 122 (1997) (noting that "most observers agree that the threshold for a finding of competency is not particularly high"). Arguably, this standard does what it is supposed to do in most cases: it ensures that the defendant has a sufficient understanding of the trial process to allow him to participate in presenting a defense. *See supra* note 8. This standard cannot, however, guard against an unfair trial when the government, at the same time that it is prosecuting the defendant, is administering medications known to impair the ability to present a defense. *See supra* Part III.B (discussing ways that involuntary psychotropic medications interfere with the ability to present a defense).

231. Courts are likely to allow a trial to proceed despite evidence of significant impairment caused by psychotropic medications, provided the impairment does not include an inability to understand the trial process. *See, e.g., McGregor v. Gibson*, 219 F.3d 1245, 1252, 1259 n.3, 1261 (10th Cir. 2000) (finding that defendant's "conduct and demeanor at trial were not so bizarre and irrational as to raise a bona fide doubt that he was incompetent," when defendant may have been overmedicated and defense attorney indicated that defendant "talked nonsense the whole time" and hindered efforts to present a defense); *State v. Mitchell*, 727 N.E.2d 254, 269 (Ill. 2000) (emphasizing that motivational or attentional side effects of psychotropic medications do not raise a bona fide doubt regarding competency; and that competency requires only that defendant's cognitive abilities not be substantially impaired: "[Consultant's] affidavit established that the combination of defendant's medications might have affected defendant's ability to make certain decisions . . . [and] may have caused defendant to appear too relaxed or detached during court proceedings. [The] affidavit simply does not establish that defendant would not have been able to understand the nature and purpose of the proceedings or to assist in his defense."); *Commonwealth v. Louraine*, 453 N.E.2d 437, 441 (Mass. 1983) (concluding defendant was competent to stand trial even though the symptoms of schizophrenia were only "controlled to some extent" by "heavy" doses of antipsychotics, which "reduced the defendant's alertness and ability to concentrate").

232. *E.g., United States v. Weston*, 206 F.3d 9, 21 (D.C. Cir. 2000) (Tatel, J., concurring) (stating that involuntary medications might be acceptable "provided that, should Weston become competent to stand trial, the district court conducts a second hearing to determine the extent to which any side effects Weston is *actually* experiencing might affect his fair trial rights"); *United*

a court should apply to evaluate whether the prejudicial effects of involuntary psychotropic drugs are within some acceptable range is, however, something of a mystery. How sedated is too sedated to receive effective assistance of counsel? How distracted is too distracted to confront witnesses? How anxious is too anxious to convey credibility? The problem, it should be emphasized, is not the defendant's sedation, distractedness, or anxiety per se, but rather the government action of causing the defendant to be sedated, distracted, or anxious.<sup>233</sup> Also, a court would almost certainly have great difficulty determining whether a particular defendant was sedated, distracted, or anxious because of the effects and side effects of involuntary medications, or because of some other factor, such as residual symptoms of the defendant's mental illness or the defendant's personality.<sup>234</sup> Finally, the effects and side effects of

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States v. Weston, 134 F. Supp. 2d 115, 137 (D.D.C. 2001) ("The Court will reassess, upon request, its determination regarding the prejudice to Weston's fair trial rights resulting from medication when testimony about the actual, not hypothetical, impact of the medication is available."); *Morgan*, 193 F.3d at 264-65 ("The district judge might also ensure that the medication posed no significant risk of altering or impairing Morgan's demeanor in a manner that would prejudice his capacity or willingness to either react to testimony at trial or to assist his counsel.").

233. In *Weston*, Judge Tatel, responding to Judge Henderson's suggestion that the inability of an involuntarily medicated defendant to present evidence of insanity is no different from a defendant's inability to recreate a state of "heat of passion" for the jury, stressed that the critical factor is whether the inability results from government action:

To be sure, due process does not require that a defendant presenting a "heat of passion" defense "duplicate his 'hot blood' in court." But because such a case involves no action by the government, it has nothing to do with the issue before us. Here the question is whether due process permits the *government* through involuntary administration of psychotropic drugs to alter the defendant so that it becomes impossible for him to appear before the jury as he was when he committed the crime.

*Weston*, 206 F.3d at 21-22 (Tatel, J., concurring) (quoting *Weston*, 206 F.3d at 15 (Henderson, J., concurring)).

Additionally, the "heat of passion" defense rests on a view of human nature as generally flawed, so that any reasonable person experiencing what the defendant experienced would have been similarly provoked. See *State v. Thornton*, 730 S.W.2d 309, 315 (Tenn. 1987) (setting aside first-degree murder conviction in favor of manslaughter because "[i]n our opinion the passions of any reasonable person would have been inflamed"); see also Glanville Williams, *Provocation and the Reasonable Man*, 1954 CRIM. L. REV. 740, 742 ("Surely the true view of provocation is that it is a concession to 'the frailty of human nature' in those exceptional cases where the legal prohibition fails of effect."), quoted in KADISH & SCHULHOFER, *supra* note 164, at 408. The insanity defense, on the other hand, excuses someone whose experience of the world is so distorted that he does not realize when he is killing someone else, or does not realize that killing someone else is wrong. See *M'Naghten's Case*, 8 Eng. Rep. 718, 722 (1843) (establishing the traditional definition of insanity). Arguably, from the typical juror's point of view, it is much easier to imagine being provoked enough to kill someone than it is to imagine being insane enough to kill someone. Consequently, the inability to demonstrate to the jury a state of insanity is arguably more costly to a defendant than is an inability to demonstrate a state of "heat of passion."

234. See *supra* notes 198, 204 (discussing the problem of distinguishing medication effects from other factors that could explain the defendant's appearance and behavior).



antipsychotic medications are so extensive that arguably the rights of every defendant who takes these medications will be affected in some way or another.<sup>235</sup> For example, if the defendant experiences extrapyramidal side effects and appears nervous,<sup>236</sup> then the jury may conclude that he lacks credibility;<sup>237</sup> on the other hand, if the defendant experiences no side effects and appears perfectly sane,<sup>238</sup> then the jury may be unable to believe that he suffered from a mental abnormality at the time of the offense.<sup>239</sup>

#### V. THE BOTTOM LINE: CIVIL COMMITMENT RATHER THAN CRIMINAL PROSECUTION

The inability to cure the prejudice caused by psychotropic medications means that courts should not allow the government to compel a defendant to take these medications during trial. The conclusion that administering involuntary psychotropic medications during trial violates the defendant's right to a fair trial might be criticized for giving an incompetent detainee the option of not proceeding to trial, by refusing to take voluntarily the psychotropic drugs that might render him competent.<sup>240</sup> The detainee's "choice,"

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235. See *supra* Part III.B (discussing ways that antipsychotic medications infringe rights at trial).

236. See *supra* notes 118-20, 132 and accompanying text (discussing extrapyramidal side effects of antipsychotic medications).

237. See *supra* note 157 and accompanying text (discussing impact of side effects on jury's assessment of defendant's credibility).

238. See *supra* note 130 and accompanying text (noting some patients' "wakening" response to antipsychotic medications).

239. See *supra* notes 181-86 and accompanying text (discussing impact of antipsychotic medication on the ability to present evidence in support of insanity defense). This problem exists not only for defendants asserting a traditional insanity defense but also for defendants asserting defenses such as partial responsibility and diminished capacity. See *supra* notes 168-69 and accompanying text (discussing partial responsibility and diminished capacity defenses).

240. On the other hand, the present system forces an incompetent detainee to choose between receiving treatment for his mental illness and receiving a fair adjudication of the charges against him. Additionally, not all incompetent detainees will refuse psychotropic medications. Particularly for detainees charged with relatively nonserious crimes, the prospect of a trial may be more desirable than the prospect of indefinite civil commitment. When antipsychotic drugs were first introduced, some courts initially found detainees incompetent to stand trial if their competency was maintained by medication; some of these detainees appealed, seeking to be able to proceed to trial. *E.g.*, *State v. Hampton*, 218 So.2d 311, 312 (La. 1969) (finding on appeal by defendant that trial court erred in ruling that "trial capacity induced by medication was insufficient"); *People v. Dalfonso*, 321 N.E.2d 379, 382 (Ill. App. Ct. 1974) (agreeing with defendant's argument that he was "competent to stand trial even though his competency may depend upon taking the prescribed medication, Haldol"); see also Steve Tomashefsky, Comment, *Antipsychotic Drugs and Fitness to Stand Trial: The Right of the Unfit Accused to Refuse Treatment*, 52 U. CHI. L. REV. 773, 791 (1985) ("[I]t should not be assumed that a defendant is automatically better off being found unfit to stand trial than being tried. The early litigation over fitness produced by antipsychotic drugs was instigated by defendants who preferred a trial to indefinite commit-

however, is not between trial and release. If a detainee refuses to take psychotropic medications voluntarily, then the government can seek to hold the detainee under civil commitment laws.<sup>241</sup> Different jurisdictions have different criteria for civil commitment, yet all provide in some way for the detention of someone who is a danger to himself or others because of a mental illness.<sup>242</sup> Some statutes are even specifically designed to address the problem of the “permanently incompetent” detainee, who cannot be brought to trial.<sup>243</sup> For example, federal law allows for the indefinite commitment of an incompetent detainee “against whom all criminal charges have been dismissed solely for reasons related to the mental condition of the person” if the detainee “is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another.”<sup>244</sup> Thus, although not all incompetent detainees who refuse medication will satisfy the requirements for civil commitment, the government should have the greatest ability to hold

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ment.”). Even those who have been convicted may not prefer involuntary psychiatric treatment over regular penal confinement. *See generally* Vitek v. Jones, 445 U.S. 480 (1980) (involving a convicted felon’s objection to being transferred from the state prison to a mental hospital). Additionally, when an incompetent detainee is charged with a relatively minor crime, the prosecutor may be sympathetic to some resolution of the charge, such as entering a *nolle prosequi*, so that the detainee can receive appropriate treatment. Problems arise when the detainee is charged with a serious crime, because the public pressure to obtain a conviction may diminish the prosecutor’s willingness to take any action other than to proceed to trial. Interview with Karl Dean, former Public Defender and present Director of Law for Metropolitan Nashville, in Nashville, Tenn. (Nov. 15, 2001).

241. *See* Jackson v. Indiana, 406 U.S. 715, 738 (1972) (noting that one of the government’s options when a detainee cannot be rendered competent to stand trial is to “institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen”); *cf.* Riggins v. Nevada, 504 U.S. 127, 145 (1992) (Kennedy, J., concurring in the judgment) (“If the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment, if appropriate, unless the defendant becomes competent through other means.”).

242. *See* REISNER, SLOBOGIN & RAI, *supra* note 170, at 641 (discussing civil commitment statutes).

243. Usually, a detainee is “permanently incompetent” because his incompetence results from a mental disorder that cannot be treated. “[I]f there is no substantial probability that the defendant will regain trial competence in the near future . . . the state can only justify further detention through the use of its regular civil commitment proceedings. The incompetent defendant is then viewed as permanently incompetent, not as potentially restorable.” Grant H. Morris & J. Reid Meloy, *Out of Mind? Out of Sight: The Uncivil Commitment of Permanently Incompetent Criminal Defendants*, 27 U.C. DAVIS L. REV. 1, 13 (1993) (footnote omitted).

244. 18 U.S.C. § 4246(a) (1994 & Supp. 1998); *see also* United States v. Sahhar, 56 F.3d 1026, 1029-30 (9th Cir. 1995) (upholding the constitutionality of § 4246, on the grounds that it “is narrowly tailored to apply only to a particular concern of the federal government: dangerous persons charged with federal crimes but found incompetent to stand trial”), *cert. denied*, 516 U.S. 952 (1995).

those detainees who pose the greatest risk of engaging in criminal activity if released.<sup>245</sup> If the government cannot hold a detainee who is so seriously mentally ill as to not satisfy the very minimal requirements for competency to stand trial,<sup>246</sup> and who, probable cause exists to believe, is endangering himself and others by engaging in criminal activity, then arguably the solution should be to change the civil commitment laws, not to compromise constitutional guarantees of fairness for the sake of obtaining a criminal conviction. Furthermore, the difficult questions<sup>247</sup> that arise when the government seeks to administer involuntary psychotropic drugs to an incompetent pretrial detainee might well be avoided altogether, in at least some cases, by a different kind of change in the civil commitment laws: enhancing the government's ability to administer involuntary psychotropic drugs to a mentally ill person before he commits a crime.<sup>248</sup>

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245. See Morris & Meloy, *supra* note 243, at 22 ("Throughout the United States, a mentally disordered person who is dangerous to others is subject to civil commitment. In a civil commitment proceeding, proof that a permanently incompetent defendant recently engaged in serious activity endangering others should suffice for an order of commitment."). Additionally, if the requirements for civil commitment are not met, the government may in extreme cases seek to continue holding the detainee under an alternate exercise of the government's police power interest in protecting the safety of the public. See *United States v. Salerno*, 481 U.S. 739, 748 (1987) ("We have repeatedly held that the Government's regulatory interest in community safety can, in appropriate circumstances, outweigh an individual's liberty interest.").

246. See *supra* note 8 (discussing competency to stand trial); see also *supra* notes 230-31 and accompanying text (stressing that the requirements for competence to stand trial are minimal).

247. See *supra* Part II (discussing difficulty courts have encountered in determining when the government may administer involuntary medications); see also *United States v. Weston*, 206 F.3d 9, 26 (D.C. Cir. 2000) (Rogers, J., concurring) ("[N]otwithstanding the district court's commendable effort to get a handle on a difficult issue, the district court made insufficient findings and did not consider all of the factors."); *State v. Garcia*, 658 A.2d 947, 971 (Conn. 1975) (indicating that "the trial court made an admirable attempt, in the absence of guidance on this complex issue, to balance the interests of the defendant and the state before issuing the medication order").

248. See Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1285 (2000) ("Numerous studies conclude that persons suffering from mental illness who follow prescribed medication regimens, or are properly treated, are significantly less dangerous than those who are not treated or who are noncompliant with prescribed medication regimens."); E. Fuller Torrey, M.D., *Violent Behavior by Individuals with Serious Mental Illness*, 45 HOSP. & COMMUNITY PSYCHIATRY 653, 659 (1994) ("The data, then, suggest that individuals with serious mental illnesses are *not* more dangerous than the general population *when they are taking their antipsychotic medication*. When they are not taking their medication, the existing data suggest that some of them are more dangerous."); *Letters from Nobody: The Shadow of Russell Weston, Jr.*, ARK. DEMOCRAT-GAZETTE, Aug. 8, 2001, at B8 (commenting on the possibility of imposing the death penalty in the *Weston* case):

If society can forcibly medicate a man to kill him, why can't it forcibly medicate a man to save him? Why did John Gibson and Jacob Chestnut have to give up their lives before the law stepped in? Why are we debating the absurdist, the Kafkaesque, question of whether to make a man sane enough to kill him, or to

Civil commitment does not, of course, achieve the same interests as does a criminal conviction.<sup>249</sup> The two primary interests that the government can achieve through criminal convictions are retribution and deterrence.<sup>250</sup> These particular interests are not well served, however, by the conviction of someone who has been denied a fair opportunity to defend himself. The theory of retribution is based on the principle that a defendant who is convicted of a crime deserves to be punished.<sup>251</sup> This principle presumes, however, that the defendant deserved to be convicted, a presumption that is not warranted when the defendant did not receive a fair trial. Similarly, the government could obtain more convictions, and thereby deter more potential criminals, by compromising the procedural protections afforded by the Fifth and Sixth Amendments.<sup>252</sup> That these amendments grant to criminal defendants such rights as the right to remain silent, to consult with an attorney, and to confront witnesses—rights that certainly tend to impair rather than enhance the government's ability to obtain convictions and deter crime—indicates that deterrence cannot be achieved, legitimately at least,<sup>253</sup> by sacrificing a basic level of fairness.

While most defendants can be tried according to the rules of fairness established by the Constitution, in some cases these rules will preclude bringing a defendant to trial, because the trial would lack a basic level of fairness. Thus, for example, the inability to render a detainee competent to stand trial does not justify bringing the detainee to trial while he is incompetent.<sup>254</sup> Similarly, the inability to bring a defendant to trial if the court suppresses the defendant's coerced confession, or evidence obtained by the police in

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leave him to his madness? Isn't there some other way, some sane way to treat the insane? Or has society gone mad, too?

249. See *United States v. Weston*, 255 F.3d 873, 881-82 (D.C. Cir. 2001).

250. See *United States v. Halper*, 490 U.S. 435, 448 (1989) (observing that "punishment serves the twin aims of retribution and deterrence" (citing *Kennedy v. Mendoza-Martinez*, 372 U.S. 144, 168 (1963))).

251. See Michael S. Moore, *The Moral Worth of Retribution*, in RESPONSIBILITY, CHARACTER AND EMOTIONS 179 (F. Schoeman ed., 1987) ("Retributivism is the view that punishment is justified by the moral culpability of those who receive it. A retributivist punishes because, and only because, the offender deserves it."), quoted in KADISH & SCHULHOFER, *supra* note 164, at 106.

252. The protections guaranteed by the Fifth and Sixth Amendments are discussed *supra* Part III.B.

253. Cf. *Ake v. Oklahoma*, 470 U.S. 68, 79 (1985) ("[A] state may not legitimately assert an interest in maintenance of a strategic advantage over the defense, if the result of that advantage is to cast a pall on the accuracy of the verdict obtained.")

254. See *Pate v. Robinson*, 383 U.S. 375, 378 (1966) ("The State concedes that the conviction of an accused person while he is legally incompetent violates due process." (citing *Bishop v. United States*, 350 U.S. 961 (1956))).

an illegal search, does not justify admitting the coerced confession<sup>255</sup> or the illegally obtained evidence.<sup>256</sup> Finally, maintaining a basic level of fairness is an interest of the government as well as of defendants.<sup>257</sup> Convicting a defendant after an unfair trial not only harms the individual defendant but also compromises the integrity of the criminal justice system as a whole.<sup>258</sup>

## VI. CONCLUSION

In deciding whether to allow the government to administer involuntary psychotropic medications to an incompetent pretrial detainee, a court must consider multiple interests of both the government and the detainee. Either way that a court decides, the ability to achieve certain of these interests will be limited, if not foreclosed altogether. If the court decides not to allow involuntary medications, the government will likely be unable to achieve its interest in adjudicating the charges against the detainee. The government also might need to pursue civil commitment to achieve its interests in protecting the health and safety of the detainee and others. On the other hand, if the court decides to allow involuntary medications, the detainee's ability to exercise procedural rights at trial will likely be diminished. Also, the detainee's demeanor as well as his mental state are likely to be altered by the medications, in ways that detract both from the jury's impression of the de-

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255. See *Jackson v. Denno*, 378 U.S. 368, 376 (1964) (observing that "[i]t is now axiomatic that a defendant in a criminal case is deprived of due process of law if his conviction is founded, in whole or in part, upon an involuntary confession"); see also *Payne v. Arkansas*, 356 U.S. 560, 568 (1958) ("[T]he admission in evidence, over objection, of the coerced confession vitiates the judgment because it violates the Due Process Clause of the Fourteenth Amendment.").

256. See *Mapp v. Ohio*, 367 U.S. 643, 655 (1961) ("We hold that all evidence obtained by searches and seizures in violation of the Constitution is, by that same authority, inadmissible in a state court.").

257. See *United States v. Brandon*, 158 F.3d 947, 960 (6th Cir. 1998) ("[A] drug that negatively affects [the defendant's] demeanor in court or ability to participate in his own defense will not satisfy the *government's* goal of a fair trial." (citing *Riggins v. Nevada*, 504 U.S. 127, 143-44 (1992) (Kennedy, J., concurring)) (emphasis added)); see also *Faretta v. California*, 422 U.S. 806, 849 (1975) (Blackmun, J., dissenting) (noting "the established principle that the interest of the State in a criminal prosecution 'is not that it shall win a case, but that justice shall be done' " (quoting *Berger v. United States*, 295 U.S. 78, 88 (1935))).

258. See *United States v. Chisolm*, 149 F. 284, 288 (S.D. Ala. 1906) (charging the jury that convicting an incompetent defendant would be worse than allowing a competent defendant to go unpunished because, in convicting an incompetent defendant, "the great safeguards which the law adopts in the punishment of crime and the upholding of justice would be rudely invaded by the tribunal whose sacred duty it is to uphold the law in all its integrity"), quoted in *Cooper v. Oklahoma*, 517 U.S. 348, 366 (1996).

tainee's character and credibility and from his ability to present evidence in support of an insanity defense.

These infringements of the detainee's interests create a substantial risk that a detainee to whom the government is administering involuntary psychotropic medications will not receive a fair trial. Because the detainee cannot be tried with a reasonable certainty of fairness, he cannot be tried at all. This is true regardless of the magnitude of the government interests that will not be achieved because the detainee will not be brought to trial; the inability to conduct a trial fairly does not justify conducting a trial unfairly. As important as the government's interests in adjudication undeniably are, they cannot justify violating a detainee's right not to be deprived of liberty without due process of law.<sup>259</sup> If the government is considered not to violate due process by bringing a detainee to trial while simultaneously compelling him to take psychotropic medications—medications that will impair his ability to confront witnesses against him, for example, or will detract from a jury's perception of his credibility, or will alter the content of his testimony—then for this detainee, the Due Process Clauses of the Fifth and Fourteenth Amendments, along with much of the Sixth Amendment, have become essentially meaningless.

Dora W. Klein\*

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259. If the defendant is charged with a capital offense, administering involuntary psychotropic medications can also violate the right not to be deprived of life without due process of law. *See Riggins*, 504 U.S. at 143-44 (Kennedy, J., concurring in the judgment) ("[S]erious prejudice could result if medication inhibits the defendant's capacity to react and respond to the proceedings and to demonstrate remorse or compassion. . . . In a capital sentencing proceeding, assessments of character and remorse may carry great weight and, perhaps, be determinative of whether the offender lives or dies." (citing William S. Geimer & Jonathan Amsterdam, *Why Jurors Vote Life or Death: Operative Factors in Ten Florida Death Penalty Cases*, 15 AM. J. CRIM. L. 1, 51-53 (1987-1988))).

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